

## Agency 30

# Department of Social and Rehabilitation Services

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**Article 1.—DEFINITIONS**

**30-1-1.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-72-23, July 28, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1976.)

**Article 2.—GENERAL**

**30-2-1. Assistance provided without discrimination.** All assistance and services provided by the Kansas state department of social and rehabilitation services shall be provided without discrimination on grounds of race, religion, color, sex, age, handicap, national origin, or ancestry. (Authorized by K.S.A. 1978 Supp. 39-708c; K.S.A. 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1974; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979.)

**30-2-2. Uniformity of interpretation.** All officers or employees of state department of social and rehabilitation services shall uniformly interpret the laws, and rules and regulations pertaining thereto, and in order to provide uniformity the agencies and individuals involved shall follow the interpretation given through handbook or manual material, or by state director's letters or other releases, or communications, from the secretary of the state department of social and rehabilitation services, or the state director of institutions. (Authorized by K.S.A. 1973 Supp. 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1974.)

**30-2-3.** (Authorized by K.S.A. 75-3304, K.S.A. 1977 Supp. 39-708c; effective Jan. 1, 1968; amended Jan. 1, 1970; amended Jan. 1, 1974; revoked May 1, 1978.)

**30-2-4.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-70-9, Dec. 4, 1969; effective Jan. 1, 1971; amended Jan. 1, 1971; amended Jan. 1, 1974; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

**30-2-5.** (Authorized by K.S.A. 39-748; effective Jan. 1, 1974; amended May 1, 1975; proposed amendment rejected, L. 1978, ch. 450; revoked, L. 1978, ch. 160, May 1, 1978; revoked May 1, 1979.)

**30-2-6.** (Authorized by K.S.A. 1978 Supp. 39-748; effective Jan. 1, 1974; amended May 1, 1978; revoked May 1, 1979.)

**30-2-7 and 30-2-8.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-2-9.** (Authorized by K.S.A. 1978 Supp. 39-708c; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

**30-2-10.** (Authorized by K.S.A. 1978 Supp. 39-708c; effective, E-79-20, Aug. 17, 1978; effective May 1, 1979; revoked May 1, 1981.)

**30-2-11. Disclosure of information to client.** Information entered into the case record subsequent to July 1, 1978 shall be made available upon request to the client or his or her legal guardian for inspection at a time mutually agreeable to the agency and the requestor except as set forth below.

(a) *Medical and psychiatric reports.* Medical and psychiatric reports shall not be made available to the requestor unless signed, written consent is obtained from the medical practitioner who rendered such report. Such reports may be released through the client's physician if the agency decides that this method of release is in the best interest of the client.

(b) *Names and addresses of complainants.* The names and addresses of complainants shall not be made available to the requestor.

(c) *Investigative reports.* Investigative reports shall not be made available to the requestor during the course of the investigation or during the time period in which the case has been referred for legal action unless an agency attorney or the prosecuting attorney to whom the case has been referred for legal action authorizes such disclosure.

(d) *Names, addresses and other information which would identify or lead to the identification of persons who have provided information to the agency.* The names, addresses or other information which would identify or lead to the identification of a person or persons who have provided information to the agency shall not be made available to the requestor unless a signed written consent is obtained from the individual whose identity the requestor wishes to be made available.

(e) *Other information.* Other information shall not be made available to the requestor if otherwise prohibited by statute or administrative regulation.

(f) *Exception.* Notwithstanding the provisions of (a), (c) and (e) above, all documents and records to be used by the agency at a fair hearing shall be made available, upon request, to the appellant or his or her representative for inspection or copying at a time mutually agreeable to the agency and the appellant or his or her representative prior to the date of the hearing. (Authorized by K.S.A. 1979 Supp. 39-708c, 39-709b; effective, E-79-20, Aug. 17, 1978; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980.)

**30-2-12. Fee for providing copies of agency documents and records to non-agency personnel.** Except as set forth in K.A.R. 30-2-12(d), the following fees may be charged for providing copies of agency documents and records to non-agency personnel: (a) A fee for copies of \$.25 per single-sided page;

(b) an additional fee not exceeding the actual cost of furnishing copies, including the cost of staff time required to make the information available; and

(c) in the case of fees for providing access to records maintained on computer facilities, the cost of any computer services, including staff time required.

(d) Exceptions. No fee shall be charged if the request for documents or records meets any of the following criteria:

(1) Is in the administration of an agency program;

(2) is in relationship to a client fair hearing;

(3) is for medical diagnosis or treatment;

(4) is from a state agency; or

(5) is pursuant to an administrative regulation authorizing the release of the document or record without the charging of a fee. This regulation shall take effect on and after April 1, 1999. (Authorized by K.S.A. 75-5321; implementing K.S.A. 76-12a10, K.S.A. 45-218; effective, E-80-13, Aug. 8, 1979; effective May 1, 1980; amended May 1, 1983; amended May 1, 1985; amended April 1, 1999.)

**30-2-13. Reliance upon certain agency actions.** Interpretations of contract and grant provisions, and the approval of contract and grant changes shall not be binding upon the agency unless they have been reduced to writing. (Authorized by K.S.A. 75-5321; effective, E-80-13, Aug. 8, 1979; effective May 1, 1980.)

**30-2-14.** (Authorized by K.S.A. 75-5321, K.S.A. 1979 Supp. 39-708c; effective, E-80-13, Aug. 8, 1979; effective May 1, 1980; revoked May 1, 1985.)

**30-2-15. Civil rights and equal employment opportunity compliance—providers, contractors, grantees and vendors.** The agency may terminate or refuse to enter into a business relationship with a provider, contractor, grantee or vendor who is not in compliance with applicable statutes, administrative regulations or executive orders concerning non-discrimination in

the provision of services or employment, affirmative action or equal employment opportunity. (Authorized by K.S.A. 75-5321; effective, E-80-13, Aug. 8, 1979; effective May 1, 1980.)

**30-2-16. Permanency planning goals for title IV-E of the federal social security act.** (a) The agency's permanency planning goal for the federal fiscal year commencing on October 1, 1999 shall be to have no more than 600 children who have been in foster care placements in excess of 24 consecutive months receive federal funding during the course of the year.

(b) Both of the following steps shall be taken by the agency to achieve the above-stated goal:

(1) A reasonable effort shall be made to make adoption assistance available on behalf of eligible children.

(2) A case review shall be initiated and a plan shall be developed for each child in the custody of the agency. (Authorized by and implementing K.S.A. 1998 Supp. 39-708c; effective, T-83-26, Sept. 22, 1982; effective May 1, 1983; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended, T-87-5, May 1, 1986; amended, T-87-29, Oct. 22, 1986; amended May 1, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 30, 1990; amended Oct. 1, 1990; amended Oct. 28, 1991; amended Oct. 5, 1992; amended Oct. 1, 1993; amended Sept. 30, 1994; amended July 2, 1999.)

**30-2-17. Administration of certain long-term care programs.** (a)(1) Subject to the federal grant requirements for medicaid under the social security act, title XIX, the "nursing facility services payment program," as that term is used in K.S.A. 1996 Supp. 75-5321a, shall include the following functions:

(A) oversight of certification and recertification of nursing facilities;

(B) provider enrollment;

(C) minimum data set collection and analysis;

(D) rate setting and payments;

(E) cost report reviews;

(F) audits;

(G) payment reconciliations;

(H) overpayment collections;

(I) penalty enforcement;

(J) compliance functions, including collection of civil money penalties; and

(K) budget preparation and management.

(2) For purposes of this regulation, the term "nursing facility" shall not include any nursing fa-

cility for mental health or intermediate care facility for the mentally retarded.

(b) The "home and community-based nursing facility waiver program," as that term is used in K.S.A. 1996 Supp. 75-5321a, means the medicaid home and community-based service waiver program for the frail elderly and targeted case management for the frail elderly.

(c) For the purposes of administering the nursing facility services payment program, the home and community-based nursing facility waiver program, and the income eligible home care program pursuant to K.S.A. 1996 Supp. 75-5321a, the secretary of aging may use, exercise, and enforce any power, duty, definition, or description established in regulations of the secretary of social and rehabilitation services as may be necessary. To the extent that federal grant requirements for the medicaid program under the social security act, title XIX, require the continued involvement by the secretary of social and rehabilitation services as the designated medicaid single state agency, the state plan, regulatory, policy making, and supervisory authority over the programs administered by the secretary of aging under K.S.A. 1996 Supp. 75-5321a shall continue to be exercised by the secretary of social and rehabilitation services. (Authorized by and implementing K.S.A. 1996 Supp. 39-708c and K.S.A. 75-5321a; effective, T-30-7-1-97, July 1, 1997; effective Oct. 3, 1997.)

### Article 3.—PROCESSING OF APPLICATION

**30-3-1.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-3-2 to 30-3-4.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; revoked May 1, 1976.)

**30-3-5.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1976.)

**30-3-6.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1976.)

**30-3-7.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1,

1971; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-3-8.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1970; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-3-9.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; revoked May 1, 1976.)

**30-3-10.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-3-11.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-3-12.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; revoked May 1, 1976.)

**30-3-13.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; revoked May 1, 1976.)

**30-3-14.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; revoked May 1, 1976.)

**30-3-15.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-3-16.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; revoked May 1, 1976.)

**30-3-17.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

#### **Article 4.—PUBLIC ASSISTANCE PROGRAM**

**30-4-1.** (Authorized by K.S.A. 1970 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1970; amended Jan. 1, 1971; revoked Jan. 1, 1974.)

**30-4-2.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1970; amended Jan. 1, 1971; amended Jan. 1, 1973; amended Jan. 1,

1974; amended May 1, 1975; revoked May 1, 1976.)

**30-4-3.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1970; amended Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1976.)

**30-4-4.** (Authorized by K.S.A. 39-709, K.S.A. 1975 Supp. 39-708c, 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-4-5.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-4-6.** (Authorized by K.S.A. 39-709, K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1969; amended, E-71-34, Aug. 11, 1971; amended Jan. 1, 1972; revoked May 1, 1976.)

**30-4-7 and 30-4-8.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective May 1, 1976; revoked May 1, 1981.)

**30-4-9.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective May 1, 1976; amended, E-77-44, Sept. 23, 1976; amended Feb. 15, 1977; revoked May 1, 1981.)

**30-4-10.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective May 1, 1976; revoked May 1, 1981.)

**30-4-11.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-719b; effective May 1, 1976; amended, E-77-44, Sept. 23, 1976; amended Feb. 15, 1977; amended May 1, 1978; revoked May 1, 1981.)

**30-4-12.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective May 1, 1976; amended, E-77-44, Sept. 23, 1976; amended Feb. 15, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-4-13.** (Authorized by K.S.A. 39-719b, K.S.A. 1976 Supp. 39-708c, 39-709; effective May 1, 1976; revoked, E-77-44, Sept. 23, 1976; revoked Feb. 15, 1977.)

**30-4-14 and 30-4-15.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective, E-77-44, Sept. 23, 1976; effective Feb. 15,



1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-4-16.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective, E-77-44, Sept. 23, 1976; effective Feb. 15, 1977; revoked May 1, 1981.)

**30-4-17.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective, E-77-44, Sept. 23, 1976; effective Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

**30-4-18.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective, E-77-44, Sept. 23, 1976; effective Feb. 15, 1977; amended May 1, 1978; revoked May 1, 1981.)

**30-4-19.** (Authorized by K.S.A. 1980 Supp. 38-827, 39-708c; effective, E-77-44, Sept. 23, 1976; effective Feb. 15, 1977; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-4-20.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective, E-77-44, Sept. 23, 1976; effective Feb. 15, 1977; amended May 1, 1978; amended May 1, 1979; revoked May 1, 1981.)

**30-4-21 to 30-4-23. Reserved.**

**30-4-24.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective May 1, 1976; amended, E-77-44, Sept. 23, 1976; amended Feb. 15, 1977; amended May 1, 1978; amended May 1, 1980; revoked, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-4-25.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective May 1, 1976; amended, E-77-44, Sept. 23, 1976; amended Feb. 15, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-4-26 to 30-4-28. Reserved.**

**30-4-29.** (Authorized by K.S.A. 1980 Supp. 19-1015, 39-708c, 39-709, 39-719b; effective May 1, 1976; amended, E-77-44, Sept. 23, 1976; amended Feb. 15, 1977; amended May 1, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-4-30.** (Authorized by K.S.A. 1980 Supp.

39-708c; effective May 1, 1978; revoked May 1, 1981.)

**30-4-31. Reserved.**

**30-4-32.** (Authorized by K.S.A. 59-2801 *et seq.*, K.S.A. 1980 Supp. 39-708c, 39-709; effective May 1, 1976; amended, E-77-44, Sept. 23, 1976; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-4-33.** (Authorized by K.S.A. 39-720, K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective May 1, 1976; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

**30-4-34. Program.** (a) The public assistance program. The public assistance program shall include the following types of assistance:

- (1) temporary assistance for families (TAF);
- (2) foster care assistance, which shall include the federal financial participation-foster care (FFP-FC) and non-federal financial participation-foster care (non-FFP-FC) programs;
- (3) general assistance (GA).

(b) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104 and K.S.A. 1995 Supp. 39-7,122, K.S.A. 1995 Supp. 39-7,123, as amended by L. 1996, Ch. 253, Sec. 7, K.S.A. 1995 Supp. 39-7,124 through 39-7,133, K.S.A. 1995 Supp. 39-709, 39-7,104, 39-7,105, 39-7,107; effective May 1, 1981; amended, T-84-8, April 1, 1983; amended May 1, 1983; amended, T-84-9, May 1, 1983; amended May 1, 1984; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-6-10-91, July 1, 1991; amended Dec. 30, 1994; amended April 1, 1995; amended Aug. 1, 1995; amended March 1, 1997.)

**30-4-35. Application process.** (a) Attention given to requests. All applications, inquiries and requests for assistance shall be given prompt attention.

(b) Who may file. An application for public assistance shall be made by each applicant in person, or by another person authorized to act on the applicant's behalf.

(c) Applications. An application for assistance shall be considered an application for any type of public assistance. The applicant or person authorized to act on behalf of the applicant shall sign the

application. If the applicant or the applicant's representative signs by mark, the names and addresses of two witnesses shall be required.

(d) Face-to-face interview. A face-to-face interview shall be required at the time of application unless there is good cause for waiving this requirement.

(e) Time in which application shall be processed.

(1) Applications for assistance shall be approved or denied within 45 days of the agency's receipt of a signed application for assistance unless either of the following requirements is met.

(A) The application for assistance has been withdrawn.

(B) The required determination of eligibility cannot be made within 45 days due to the failure of the applicant or a collateral to provide necessary information.

(2) If the agency takes action to deny an application within the 45-day time period and the applicant reapplies or provides required information within the 45-day time period, the application shall be reactivated, and, if eligible, benefits shall be provided from the date of application.

(f) Changes in circumstances.

(1) All changes in circumstances that affect assistance shall be acted upon within 30 days of being reported to the agency.

(2) Changes that result in an increase in benefits shall become effective in the month following the month in which the changes are reported, provided that any necessary verification is received within 10 days of request. If verification is not provided in a timely manner, the change shall be effective in the month following the month in which verification is received.

(g) The effective date of this regulation shall be July 1, 1997. (Authorized by and implementing K.S.A. 1996 Supp. 39-708c; effective May 1, 1981; amended May 1, 1984; amended May 1, 1988; amended July 1, 1989; amended July 1, 1997.)

**30-4-35w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-36. Redetermination of eligibility process.** (a) Purpose of redetermination. The purpose of the redetermination shall be to give the recipient an opportunity to bring to the attention of the agency the recipient's current situation and to give the agency an opportunity to review

the factors of eligibility in order to determine the recipient's continuing eligibility for assistance.

(b) Face-to-face interview. A face-to-face interview shall be required at the time of each redetermination unless there is good cause for waiving this requirement.

(c) Frequency of redetermination. A recipient's eligibility for assistance shall be redetermined as often as a need for review is indicated. All cases shall be reviewed at least once each 12 months. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended May 1, 1988.)

**30-4-37. Reserved.**

**30-4-38. Rights of applicants and recipients.** (a) Right to information. Each applicant or recipient shall have the right to be provided with information concerning the types of assistance which are provided by the agency. Upon request, the agency shall furnish each applicant with information and shall explain the categories of assistance and the eligibility factors.

(b) Right to make application. Each applicant shall have the right to make application regardless of any question of eligibility or agency responsibility. The right of any individual to make application shall not be abridged.

(c) Right to private interview. Each applicant or recipient, upon request, shall have a right to a private interview when discussing individual situations with the agency.

(d) Right to an individual determination of eligibility for assistance. Each applicant or recipient shall be given an opportunity to present any request and to explain the individual's situation.

(e) Right to withdraw from program. Each applicant shall have the right to withdraw the application at any time between the date the application is signed and the date the notice of the agency's decision is mailed. Any recipient may withdraw from a program at any time.

(f) Right to prompt decision. Each applicant shall have the right to have a decision rendered on an application within 45 days of its receipt by the agency. Each recipient shall have the right to have a decision rendered on any formal request within 30 days of its receipt by the agency.

(g) Right to correct amount of assistance. Each recipient, if eligible, shall be entitled to the correct amount of assistance, based upon established budgetary standards.

(h) Right to written notification of action. Each applicant or recipient shall have the right to a written notification of agency action concerning eligibility for assistance.

(i) Right to equal treatment. Each applicant or recipient shall have the right to be treated in the same manner as other applicants or recipients who are in similar circumstances.

(j) Right to a fair hearing. Each applicant or recipient shall have the right to request a fair hearing if dissatisfied with any agency decision or lack of action in regard to the application for or receipt of assistance. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1981; amended May 1, 1984.)

**30-4-39. Responsibilities of applicants and recipients.** Each applicant or recipient shall meet these requirements: (a) Supply, insofar as the applicant or recipient is able, information essential to the establishment of eligibility;

(b) report changes of circumstances within 10 calendar days;

(c) give written permission for release of information regarding resources, when needed;

(d) cooperate with the agency in establishing the paternity of a child born out of wedlock for whom assistance is claimed and in performing the following:

(1) Obtaining support payments for the applicant or recipient and for any child for whom assistance is claimed; and

(2) obtaining any other payments or property due the applicant or recipient or any child for whom assistance is claimed; and

(e) meet each applicant's or recipient's own needs insofar as that individual is capable.

This regulation shall be effective on and after October 1, 2003. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, K.S.A. 39-709, and K.S.A. 39-719b; effective May 1, 1981; amended May 1, 1982; amended May 1, 1984; amended May 1, 1986; amended Oct. 1, 1997; amended July 1, 1998; amended Oct. 1, 2003.)

**30-4-40. Agency responsibility to applicants and recipients.** (a) On the request of any applicant or recipient, the applicant's or recipient's rights and responsibilities shall be explained by the agency.

(b) Each applicant and recipient shall be informed of the following requirements placed upon the agency.

(1) Periodic redeterminations. Periodic rede-

terminations of eligibility shall be made if the application is approved.

(2) Fraud. Any fraudulent application for or receipt of assistance shall be investigated and referred for legal action.

(3) Public list. A public list of cash recipients of GA, which shall be limited to name, address, and amount of cash assistance received, shall be prepared and maintained.

(4) Release of confidential information. Unless otherwise prohibited by law, confidential information shall be released by the agency when the release is directly related to one of these duties:

(A) The administration of the public assistance program;

(B) an investigation or criminal or civil proceeding being conducted in connection with the administration of the program;

(C) the reporting of a fugitive felon's address to local and state law enforcement officials. Such a report shall be made only when the law enforcement official furnishes the recipient's name and social security number and satisfactorily demonstrates that the individual is a fugitive felon, that the location or apprehension of the fugitive felon is within the law enforcement officer's official duties, and that the request is made in the proper exercise of those duties;

(D) the reporting of an applicant's or recipient's intention to commit a crime to the appropriate law enforcement officials;

(E) release of confidential information concerning TAF and foster care applicants and recipients under certain circumstances as required under 42 U.S.C.A. 602(a)(9); or

(F) the reporting to the immigration and naturalization service of the name, address, and other identifying information of any individual who the agency knows is residing unlawfully in the United States.

(c) This regulation shall take effect on and after October 1, 1997. (Authorized by and implementing K.S.A. 1996 Supp. 39-708c; effective May 1, 1981; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1987; amended March 1, 1997; amended Oct. 1, 1997.)

**30-4-41. Assistance planning.** (a) Definitions.

(1) "Family group" means the applicant or recipient and all individuals living together in which there is a relationship of legal responsibility or a caretaker relationship.



(2) "Mandatory filing unit" means all persons in the family group whose needs or resources are required to be considered in determining eligibility and amount of payment as outlined in K.A.R. 30-4-70(e) for TAF purposes and K.A.R. 30-4-90 for GA purposes. If the agency is unable to determine who is required to be a member of the mandatory filing unit as a result of an applicant's or recipient's failure to cooperate in providing necessary information or in complying with an eligibility requirement that is within the applicant's or recipient's control, those persons who would otherwise be required to be in the mandatory filing unit had the applicant or recipient cooperated shall be ineligible for assistance.

(3) "Caretaker" means any of the following persons:

(A) the parent or parents, including the parent or parents of an unborn child; or

(B) the person who is assigned the primary responsibility for the care and control of the child as one of the following representatives:

(i) a guardian, conservator or a relative, as defined in K.A.R. 30-4-70(b); or

(ii) a legal custodian, when based on an approved social service plan.

Caretaker status shall be extended to the spouse of a non-parental caretaker.

(4) "Eligible caretaker" means a caretaker who is considered in the plan with the child.

(5) "Legally responsible relative" means the person who has the legal responsibility to provide support for the person in the plan.

(b) The assistance plan shall consist of those members of the mandatory filing unit and any other persons in the family group for whom assistance is requested and eligibility is determined. Any individual excluded from the assistance plan shall not be eligible in a separate assistance plan.

(c) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, and K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended July 1, 1989; amended July 1, 1991; amended Jan. 2, 1992; amended March 1, 1997.)

**30-4-41w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-42 to 30-4-49. Reserved.**

**30-4-50. Assistance eligibility, general.**

(a) General requirements. The requirements set forth in K.A.R. 30-4-51 through 30-4-64 shall apply to the TAF, foster care, and GA programs except as noted.

(b) Time-limited assistance. A family group shall not be eligible for TAF if either of the following conditions is met:

(1) The family group contains at least one adult member who has received TAF, including similar assistance received in any other state, for 60 calendar months beginning on and after October 1, 1996.

(2) The family group has received TAF for any 60 calendar months beginning on and after October 1, 1996, during which time one or more adult family members residing in the family group were ineligible due to the provisions of K.A.R. 30-4-54(b), K.A.R. 30-4-140(d), or subsections (c) and (d) of this regulation.

(c) Denial of assistance for fugitive felons and probation and parole violators. Assistance shall not be provided to a fugitive from justice by reason of a felony conviction or charge, or to a person who is violating a condition of probation or parole imposed under federal or state law.

(d) Denial of assistance for felony drug-related convictions. Assistance shall not be provided to any person convicted of a felony offense occurring after August 22, 1996 and involving the possession, use, or distribution of a controlled substance, unless the person meets one of the following criteria:

(1) Has been assessed by a licensed substance abuse treatment provider as not requiring substance abuse treatment; or

(2) has been assessed and recommended for substance abuse treatment by a licensed substance abuse treatment provider and meets one of the following criteria:

(A) Is participating in a licensed substance abuse treatment program; or

(B) has successfully completed a licensed substance abuse treatment program.

(e) Requirements for special projects. Certain eligibility requirements may be waived by the sec-

retary, and additional eligibility requirements for all, or designated areas, of the state may be adopted by the secretary for the purpose of utilizing special project funds or grants or for the purpose of conducting special demonstration or research projects.

This regulation shall be effective on and after July 1, 2004. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, K.S.A. 39-709, and K.S.A. 39-719b; effective May 1, 1981; amended May 1, 1983; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Oct. 1, 1989; amended, T-30-10-1-96, Oct. 1, 1996; amended Jan. 17, 1997; amended March 1, 1997; amended July 1, 1998; amended Oct. 1, 2000; amended July 1, 2004.)

**30-4-50w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-51. Eligibility process.** The determination of eligibility shall be based upon information provided by the applicant or recipient. If the information is unclear, incomplete, conflicting or questionable, a further review, including collateral contacts, shall be required. Applicants or recipients shall be eligible for assistance only when all applicable eligibility factors have been met. (Authorized by K.S.A. 1980 Supp. 39-708c; implementing K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective May 1, 1981.)

**30-4-52. Act in own behalf.** (a) Emancipated minor. "Emancipated minor" means a person who is age 16 or 17 and who is or has been married, or a person who is under the age of 18 and who has acquired the rights of majority through court action.

(b) Ability to act on own behalf. Each applicant or recipient shall be legally capable of acting on that individual's own behalf. Incapacitated persons or minors shall not be eligible to receive assistance unless a caretaker applies for assistance on that person's behalf. Emancipated minors shall be eligible to receive assistance on their own behalf. Unemancipated minors shall not be deemed capable of acting on their own behalf and shall reside with a caretaker in order to be eligible for assistance, except when one of the following conditions exists.

(1) Either the parents of the minor are insti-

tutionalized or the minor has no parent who is living or whose whereabouts are known, and there is no other caretaker who is willing to assume parental control of the minor.

(2) The health and safety of the minor has or would be jeopardized by remaining in the household with the minor's parents or other caretakers.

(c) This regulation shall take effect on and after July 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c and K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended May 1, 1984; amended Jan. 4, 1993; amended Oct. 1, 1993; amended March 1, 1997; amended Oct. 1, 1997; amended July 1, 1998.)

**30-4-52w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 1; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-53.** This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 1985 Supp. 39-708c; implementing K.S.A. 1985 Supp. 39-708c, 39-709; effective May 1, 1981; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; revoked March 1, 1997.)

**30-4-53w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-54. Citizenship, alienage, and residence.** (a) Definition. "Resident" means any person who is living in the state voluntarily, with no intention of presently moving from the state, and who is not living in the state for a temporary purpose.

(1) Any child living in the state shall be considered a resident.

(2) For TAF, any person who has entered the state with a job commitment or who is seeking employment in the state shall be considered a resident.

(3) For GA, any individual who owns an automobile or other motor vehicle that is not registered in this state, but that is required by law to be registered in this state shall not be considered a resident.

(b) Citizenship and alienage. Each applicant or

recipient shall be a citizen of the United States or shall be an alien who meets the conditions in either paragraph (1) or (2).

(1) The individual entered the United States before August 22, 1996 and meets one of these conditions:

(A) Is a refugee, including persons who are Cuban or Haitian entrants or admitted as Amerasian immigrants;

(B) is granted asylum;

(C) has deportation withheld;

(D) is a lawful permanent resident;

(E) is an honorably discharged veteran or currently on active duty in the armed forces or is the spouse or unmarried dependent child of such an alien;

(F) is paroled into the United States for at least one year; or

(G) is granted conditional entry.

(2) The individual entered the United States on or after August 22, 1996 and meets one of these conditions:

(A) Is a refugee, including persons who are Cuban or Haitian entrants or admitted as Amerasian immigrants;

(B) is granted asylum;

(C) has deportation withheld;

(D) is an honorably discharged veteran or currently on active duty in the armed forces or is the spouse or unmarried dependent child of such an alien;

(E) is a lawful permanent resident who has resided in the United States at least five years;

(F) is paroled into the United States for at least one year and has resided in the United States at least five years; or

(G) is granted conditional entry and has resided in the United States for at least five years.

(c) Residence. Each applicant or recipient shall be a resident of the state of Kansas. Temporary absence from the state, with subsequent returns to the state, or intent to return when the purposes of the absence have been accomplished, shall not be considered to interrupt continuity of residence. Residence shall be considered to be maintained until abandoned or established in another state. (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 1997 Supp. 39-708c, K.S.A. 39-719b, and K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended Oct. 1, 1989; amended, T-30-2-20-97, March 1, 1997; amended May 16, 1997; amended June 26, 1998.)

**30-4-54w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-55. Cooperation.** (a) Establishment of eligibility. Each applicant, recipient, or ineligible caretaker shall cooperate with the agency in the establishment of eligibility as provided in K.A.R. 30-4-39. Failure to provide information necessary to determine eligibility shall render the family group ineligible for assistance.

(b) Social security number. Each applicant or recipient shall provide the agency with the applicant's or recipient's social security number. Failure to provide the number, or failure to apply for a number if the applicant or recipient has not previously been issued a number, shall render the applicant or recipient ineligible for assistance.

(c) Paternity and support.

(1) The caretaker who is applying for or receiving assistance shall cooperate with the agency in establishing the paternity of any child born out of wedlock for whom assistance is claimed, and in obtaining support payments for the caretaker and for any child for whom assistance is claimed. Failure to cooperate in any assistance program administered by the secretary in which paternity and support cooperation is required shall render the mandatory filing unit of which the child is a member ineligible for assistance unless the caretaker demonstrates good cause for refusing to cooperate. The period of ineligibility shall be as follows:

(A) For the first failure, until the caretaker cooperates; and

(B) for any subsequent failure, two months or until the person cooperates, whichever is longer.

(2) Cooperation shall include the following actions:

(A) Appearing at the local child support enforcement office, as necessary, to provide information or documentation needed to establish the paternity of a child born out of wedlock, to identify and locate the absent parent, and to obtain support payments;

(B) appearing as a witness at court or at other proceedings as necessary to achieve the child support enforcement objectives;

(C) forwarding to the child support enforcement unit any support payments received from the absent parent that are covered by the support assignment;

(D) establishing and maintaining an agreement

to repay assigned support that was retained by the caretaker; and

(E) providing information, or attesting to the lack of information, under penalty of perjury.

(d) Potential resources. Each applicant or recipient shall cooperate with the agency in obtaining any resources due the applicant, recipient, or child for whom assistance is claimed and shall cooperate with the group health plan enrollment process in accordance with K.A.R. 30-6-55(f). Failure to cooperate without good cause shall render ineligible for assistance the mandatory filing unit of which the applicant, recipient, or child for whom assistance is claimed is a member.

(e) Third party resources. Each applicant or recipient shall cooperate with the agency in identifying and providing information to assist the agency in pursuing any third party who may be liable to pay for medical services under the medical assistance program. Failure to cooperate without good cause shall render the applicant or recipient ineligible for assistance.

(f) This regulation shall be effective on and after October 1, 2003. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, 39-709, and 39-719b; effective May 1, 1981; amended May 1, 1982; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended Jan. 4, 1993; amended March 1, 1997; amended July 1, 1998; amended Oct. 1, 2003.)

**30-4-55w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and 39-709, as amended by L. 1994, Chapter 265, Section 8; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-56.** This rule and regulation shall expire on July 1, 1989. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked July 1, 1989.)

**30-4-57.** This rule and regulation shall expire on October 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 29, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended May

1, 1985; amended May 1, 1986; amended, T-87-33, Dec. 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended July 1, 1989; revoked Oct. 1, 1989.)

**30-4-58.** This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, K.S.A. 1988 Supp. 39-709, K.S.A. 39-719b; effective May 1, 1981; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; revoked March 1, 1997.)

**30-4-58w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and 39-709, as amended by L. 1994, Chapter 265, Section 8; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-59. Strikes.** (a) An applicant or recipient shall be ineligible for assistance if the person is participating in a strike. If the applicant or recipient is a legally responsible caretaker, the mandatory filing unit of which that individual is a member shall be ineligible for assistance.

(b) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended March 1, 1997.)

**30-4-59w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-60. Living in a public institution.** (a) Definition. "Public institution" means any institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(b) Living arrangement. Each applicant or recipient living in a public institution shall be ineligible for assistance, except that any otherwise eligible recipient admitted to a public institution for short term medical care or diagnosis shall be eligible for assistance, if needed, for a period not to exceed three months. Any individual who is physically residing in a jail or penitentiary or under the



care, custody and control of a law enforcement official shall be ineligible unless the individual is on probation, parole, or on bail. (Authorized by K.S.A. 1983 Supp. 39-708c; implementing K.S.A. 1983 Supp. 39-708c, 39-709, K.S.A. 39-719b; effective May 1, 1981; amended May 1, 1984.)

**30-4-60w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and 39-709, as amended by L. 1994, Chapter 265, Section 8; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-61. Supplemental security income benefits.** (a) An applicant or recipient receiving supplemental security income benefits shall be ineligible for assistance. A caretaker shall not be denied eligibility for assistance for the reason that a child is receiving supplemental security income benefits. This provision shall not be applicable to a foster care child placed in a foster family home.

(b) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709, K.S.A. 39-719b; effective May 1, 1981; amended March 1, 1997.)

**30-4-61w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-62.** This rule and regulation shall expire on October 1, 1989. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1988 Supp. 39-7,103; effective May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-33, Dec. 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended July 1, 1989; revoked Oct. 1, 1989.)

**30-4-63.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, 39-7,103; effective, T-30-7-29-88, July 29, 1988; effective Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; revoked, T-30-7-2-90, July 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991;

amended, T-30-6-10-91, July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended Oct. 1, 1993; amended Aug. 1, 1995; amended July 1, 1996; revoked March 1, 1997.)

**30-4-63w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c, 39-7,103, and K.S.A. 1994 Supp. 39-7,104, 39-7,105, and 39-7,107; effective Dec. 30, 1994; amended Aug. 1, 1995; revoked March 1, 1997.)

**30-4-64. Work program requirements.** Each applicant or recipient of TAF, unless exempted, shall be required to seek and retain employment and, if assigned, participate in one or more components of the work program. Any exempt applicant or recipient may volunteer for participation in the program. The geographic areas in the state and the public assistance programs in which work program requirements are to be enforced shall be designated by the secretary. The administration of the work program shall be within the limits of appropriations. (a) Exemptions. The following persons shall be exempt from the work requirements:

(1) Any person who is age 17 or younger or who is age 18 and working toward attainment of a high school diploma or its equivalent. This exemption shall not be claimed by a female who is pregnant or a parent of a child in the home and who has not yet attained a high school diploma or its equivalent;

(2) any person who is 60 years of age or older;

(3) any person who is needed in the household because another member of the household requires the person's presence due to illness or incapacity and no other appropriate member of the household is available to provide the needed care; and

(4) any parent or other caretaker who is personally providing care for a child under age one. Only one person in a case may be exempt on the basis of providing care for a child under age one and may claim the exemption only for a total of 12 months. This exemption shall not be claimed under any of the following circumstances:

(A) A custodial parent or pregnant woman under the age of 20 does not possess a high school diploma or its equivalent.

(B) The other parent, stepparent, or caretaker in the home is exempt from the work program requirements for a reason other than the reasons

specified in paragraphs (a)(1), (2), and (3) and is available for and capable of providing child care.

(C) Both parents of the child are present, except as noted in paragraph (a)(4)(B) of this regulation.

(b) Participation requirements. Each applicant or recipient shall seek and retain employment and, if assigned, shall participate in one or more components of an agency-approved, work-related program directed toward a plan of self-sufficiency. The work program may include the following components:

(1) Job search. Each assigned person shall participate in job search activities, which may include agency-approved job clubs and supervised job search activities.

(2) Work experience. Each assigned person shall participate in work experience activities, which may include the opportunity to regain work skills, learn new skills, test interests and skills on the job, gain a work history, and obtain a work reference.

(3) Education and training. Each assigned person shall participate in supervised education and training activities that are aimed at facilitating a person's movement toward self-sufficiency and employment retention. These supervised education and training activities may include vocational training, adult basic education, literacy training, general educational development, and postsecondary education and training.

(4) Work supplementation. Each assigned person shall participate in a work supplementation program in which an employer receives a wage subsidy from money diverted from public assistance grants for employing participants.

(5) Job readiness. Each assigned person shall participate in job readiness activities, which may include employment counseling and life skills.

(6) Community service. Each assigned person shall participate in supervised community service activities.

(c) Support costs. Payment of support costs shall be provided to participants. Support costs may include the following:

(1) Transportation expenses for each person participating in a work program activity in accordance with an agency-approved plan;

(2) child care expenses, as necessary for the person to participate in a work program activity in accordance with an agency-approved plan; and

(3) education and training costs for each par-

ticipant based on an agency-approved plan, which may include tuition, books, and fees.

(d) Transitional expenses. Payment for transitional expenses may be provided to each participant who loses eligibility for TAF. Transitional expenses may include the following:

(1) Transportation expenses;

(2) child care expenses; and

(3) expenses for other transition-related services if approved by the secretary or the secretary's designee.

(e) Penalty.

(1) A person who is required to participate in the work program shall be ineligible for assistance if one of the following circumstances occurs in any assistance program administered by the secretary in which work program participation is required:

(A) If the person fails without good cause to cooperate in the work assessment process or participate in the program;

(B) if the person refuses without good cause a bona fide referral for or offer of employment;

(C) if the person terminates employment without good cause;

(D) if the person is terminated from employment by voluntarily making oneself unacceptable without good cause; or

(E) if the person reduces earnings without good cause.

(2) The period of ineligibility shall continue until the person cooperates. If the person is an adult, the mandatory filing unit of which the person is a member shall also be ineligible.

(f) Good cause. Each individual who presents verification that the individual meets one or more of the following criteria shall be determined to have good cause for failing to participate in the work program:

(1) The individual is exempt from participation in the program.

(2) The individual was incapable of performing the activity.

(3) Performance of the activity was so dangerous or hazardous according to occupational safety and health administration (OSHA) standards as to make a refusal to perform the activity or termination of the activity a reasonable one.

(4) Child care or day care for an incapacitated individual living in the same home is necessary for an individual to participate or continue to participate in the program, and the care is not available.

(5) The total daily commuting time to and from home to the activity to which the individual is as-

signed exceeds two hours, not including the transporting of a child to and from a child care facility. If a longer commuting distance is generally accepted in the community, the round trip commuting time shall not exceed the generally accepted community standards.

(6) The failure occurred in the month the individual's pregnancy was terminated or the two following months.

(7) A single custodial parent has demonstrated the inability to obtain needed child care for a child under six, because of one or more of the following reasons:

(A) Unavailability of appropriate child care within a reasonable distance from the individual's home or work site;

(B) unavailability or unsuitability of informal child care. "Informal child care" shall mean care that is legally exempt from regulation; or

(C) unavailability of appropriate and affordable formal child care arrangements.

(8) The individual was a victim of domestic violence, and compliance with program requirements would increase the risk of harm for the individual or any children in the individual's care.

(g) This regulation shall be effective on and after January 1, 2007. (Authorized by and implementing K.S.A. 39-708c and K.S.A. 39-7,103; effective Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; revoked, T-30-7-2-90, July 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991; amended, T-30-6-10-91, July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended Oct. 1, 1993; amended Aug. 1, 1995; amended July 1, 1996; amended March 1, 1997; amended July 1, 1998; amended April 1, 1999; amended Dec. 1, 1999; amended May 1, 2001; amended Jan. 1, 2007.)

**30-4-64w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c, 39-7,103, and K.S.A. 1994 Supp. 39-7,104 and 39-7,105; effective Dec. 30, 1994; amended Aug. 1, 1995; revoked March 1, 1997.)

**30-4-65. Reserved.**

**30-4-65w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and K.S.A. 1994

Supp. 39-7,126; effective Aug. 1, 1995; revoked March 1, 1997.)

**30-4-66 to 30-4-69. Reserved.**

**30-4-70. Eligibility factors specific to the TAF program.** To be eligible for TAF, each applicant or recipient shall meet the applicable general eligibility requirements of K.A.R. 30-4-50 and the specific eligibility requirements set forth below.

(a)(1) Child in family. To be eligible for TAF, the applicant's or recipient's family group shall include at least one eligible child. If the only child in the family group is an SSI recipient, the family group may qualify for assistance.

(2) For purposes of this regulation, "child" means a child who meets either of these requirements:

(A) is under the age of 18, including an unborn child; or

(B) is age 18 and in secondary school or working towards the attainment of a GED.

(b) Living with a caretaker. For the family group to be eligible for TAF, the eligible child or children shall be residing with one or more of these individuals:

(1) Any blood relative who is within the fifth degree of kinship to the child, including any of the following relatives:

(A) Parents;

(B) siblings;

(C) nephews;

(D) nieces;

(E) aunts;

(F) uncles; and

(G) persons of preceding generations who may be denoted by prefixes of grand, great, great-great, or great-great-great;

(2) a stepfather, stepmother, stepbrother, or stepsister;

(3) a legally adoptive parent or parents or another relative or relatives of adoptive parents as noted in paragraphs (1) or (2) above;

(4) a guardian or conservator or a legal custodian when based on an approved social service plan; or

(5) a spouse of any of those persons named in the above groups or a former spouse of any of those persons if marriage is terminated by death or divorce.

(c) Temporary absence. Any person who is out of the home temporarily for a period of 90 days or less or for employment shall remain eligible.

(d) Assignments of support. Each caretaker who is applying for or receiving TAF on his or her own behalf or on behalf of any other family member shall assign to the secretary any accrued, present, or future rights to support from any other person that the caretaker may have on his or her own behalf, or on behalf of any other family member for whom the caretaker is applying for or receiving TAF.

(e) Persons in the family group whose needs shall be considered.

(1) The needs of each child who meets the criteria of subsection (a) of this regulation and the needs of the child's parent, stepparent, or both shall be included in the determination of assistance.

(2) The needs of an eligible child's caretaker, other than a parent or stepparent, shall be considered in the determination of assistance if requested. If the caretaker's needs are included, the caretaker's spouse and any children of the caretaker who meet the criteria of subsection (a) of this regulation shall also be considered.

(3) In determining eligibility, the needs of each of the following caretakers and children shall be excluded, while the resources of these caretakers and children shall be included, unless the resources are specifically exempt:

(A) Any SSI recipient;

(B) any person who is ineligible due to a sanction;

(C) any child whose needs are met through foster care payments;

(D) any alien who is ineligible because of the citizenship and alienage requirements or sponsorship provisions;

(E) unborn children;

(F) a teen parent, as defined in subsection (f) of this regulation; and

(G) any person denied assistance based on the provisions of K.A.R. 30-4-50(c) or (d).

(f) Teen parents under age 18. A parent under age 18 of a child at least 12 weeks of age shall not be eligible for assistance when both of these circumstances are met:

(1) The parent is unmarried.

(2) The parent has not obtained a high school diploma or its equivalent, or is not working toward attainment of a high school diploma or its equivalent.

(g) The effective date of this regulation shall be July 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 1997 Supp. 39-

708c, K.S.A. 39-719b, K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended July 1, 1989; amended March 1, 1997; amended Oct. 1, 1997; amended July 1, 1998.)

**30-4-70w.** This rule and regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c, 39-719b, and L. 1994, Chapter 265, Section 7; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-71.** This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 1980 Supp. 39-708c; implementing K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective May 1, 1981; revoked March 1, 1997.)

**30-4-71w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and 39-719b; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-72.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; revoked March 1, 1997.)

**30-4-72w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 7; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-73.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective May 1, 1981; amended, E-82-19, Oct. 29, 1981; amended May 1, 1982; amended, T-83-38, Nov. 23, 1982; amended May 1, 1983; amended July 1, 1989; amended Oct. 1, 1989; amended April 1, 1990; amended Oct. 1, 1990; amended Oct. 1, 1992; amended May 3, 1993; revoked March 1, 1997.)

**30-4-74.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May



1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; revoked March 1, 1997.)

**30-4-74w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 7; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-75.** This rule and regulation shall expire on July 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; revoked July 1, 1989.)

**30-4-76 and 30-4-77. Reserved.**

**30-4-78.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1983; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked March 1, 1997.)

**30-4-79. Reserved.**

**30-4-80. Eligibility factors specific to the FFP-FC program.** Each child, as defined in K.A.R. 30-4-70, shall meet the eligibility requirements set forth below. In addition, if the child of an FFP-FC recipient and the FFP-FC recipient are living together in the same foster care living arrangement, the recipient's child shall be deemed to meet the eligibility requirements of the FFP-FC program. (a) General eligibility requirements. Each child shall meet the general eligibility requirements of K.A.R. 30-4-50.

(b) Removed from the home of a relative. The child shall have been removed from the home of a relative as a result of a judicial determination, or the child shall have lived with the relative within six months before the month in which the proceedings were initiated and shall have been placed in a foster home or child care facility as a result of this determination.

(c) Child in need. The child's eligibility shall be determined on a calendar-month basis. Total budgetary requirements shall be compared with total applicable income. If there is a deficit, the child shall be determined to be in need if the child

owns property with a value not in excess of allowable limits.

(d) Court order. A written order of commitment shall be issued giving the secretary care, custody, and control of the child.

(e) Case plan. The child shall have a case plan designed to achieve placement in the least restrictive setting available and in close proximity to the parents' home. The case plan shall be consistent with the best interest and special needs of the child.

(f) Administrative review. The child's status shall be reviewed periodically but not less than once every six months. The review shall be open to the participation of the parents of the child. The review shall be conducted by a panel of appropriate persons. The panel shall include at least one person who is not responsible for the case management of either the child or the parents under review. The administrative review shall determine the future status of the child including whether the child should be returned to the parent, continued in foster care for a specified period, placed for adoption, or continued in foster care on a permanent or long-term basis.

(g) Living arrangement. The child shall be living in a foster family home or a private, nonprofit child care facility. The home or facility shall be approved by the agency for placement.

(h) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec 104; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended March 1, 1997.)

**30-4-81 to 30-4-84. Reserved.**

**30-4-85.** (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 1982 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-83-9, April 29, 1982; revoked May 1, 1983.)

**30-4-85a.** This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c; implementing K.S.A. 1995 Supp. 39-709; effective, T-84-9, March 29, 1983; effective May 1, 1984; amended May 1, 1985;

amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended July 1, 1989; amended Oct. 1, 1989; amended April 1, 1990; amended June 1, 1993; amended, T-30-9-16-93, Sept. 16, 1993; amended Nov. 8, 1993; amended Jan. 31, 1996; amended July 1, 1996; revoked March 1, 1997.)

**30-4-86 to 30-4-89. Reserved.**

**30-4-90. Eligibility factors specific to the GA program.** (a) To be eligible for GA, each applicant or recipient shall meet the applicable general eligibility requirements of K.A.R. 30-4-50 and the following specific eligibility requirements:

(1) Each applicant or recipient shall be ineligible for GA under any of the following circumstances:

(A) The applicant or recipient is eligible for a federal cash program.

(B) The applicant or recipient has been denied or rendered ineligible for a federal cash program due to a voluntary action on the part of the applicant or recipient.

(C) The applicant or recipient has been determined ineligible for or has been denied social security disability benefits, unless both of the following conditions are met:

(i) The individual is exercising appeal rights at any level through the appeals council. In this case, the individual may receive assistance until social security disability benefits are awarded or until the individual is denied either disability benefits or consideration by the appeals council.

(ii) Credible, competent medical evidence exists, as determined by the social security administration or by an entity designated by the social security administration or the state of Kansas to make the determination that the individual is disabled as defined in title XVI of the social security act and is unable to engage in employment.

(D) The applicant or recipient does not have a medically determinable severe impairment, as defined in title XVI of the social security act, as determined by the social security administration or by an entity designated by the social security administration or the state of Kansas to make this determination.

(2) Each applicant or recipient is disabled or has a medically determinable severe impairment, as defined in title XVI of the social security act, as determined by the social security administration or by an entity designated by the social security

administration or the state of Kansas to make this determination.

(3) The needs of the applicant or recipient and the spouse of the applicant or recipient shall be included in the same assistance plan, if the applicant or recipient and the spouse are living together, except for persons who are not otherwise eligible. In determining eligibility, the needs of each of the following persons in the family group who are not otherwise eligible shall be excluded while the resources of those persons shall be included, unless the resources are specifically exempt:

(A) Any SSI recipient;

(B) any person denied assistance based on the provisions of K.A.R. 30-4-50 (c) or (d);

(C) any person who is ineligible due to a sanction; and

(D) any alien who is ineligible because of the citizenship and alienage requirements or sponsorship provisions.

(b)(1) A presumptive eligibility determination shall be made for each person who is being released from Osawatomie state hospital, rainbow mental health facility, Larned state security hospital, or Larned correctional mental health facility, in accordance with an approved discharge plan. Minimally, the presumptive determination shall be based on available information concerning the person's income and resources. The general eligibility requirements of K.A.R. 30-4-50 may be waived until a formal eligibility determination is completed. The time limit specified in subsection (e) of this regulation shall be waived for the period during which assistance is provided in accordance with paragraph (b)(2) of this regulation.

(2) The assistance provided shall equal 100 percent of the applicable GA budgetary standards, and the requirements of K.A.R. 30-4-140 (a)(1) shall be waived. The assistance shall not extend beyond the month of discharge and the two following months, except that the assistance may be extended by the secretary beyond the three-month limitation for good cause.

(c) Each applicant or recipient who refuses to authorize the department to file for and claim reimbursement from the social security administration for the amount of GA provided to the individual, pending a determination of eligibility for the supplemental security income program, shall be ineligible for GA.

(d) Each applicant or recipient who fails or refuses to cooperate with legal counsel or any other

entity assigned by the agency or retained by the applicant or recipient to aid, advise, assist, or represent the applicant or recipient with regard to applying for and securing social security disability benefits shall be ineligible for GA.

(e) Assistance under this regulation shall be limited to a lifetime maximum of 24 calendar months, unless one of the following hardship criteria is met:

(1) The individual's initial application for social security disability benefits is still pending the initial determination or is currently on appeal. If the individual is otherwise eligible and is either awaiting the initial determination or exercising appeal rights at any level through the appeals council, the individual may receive assistance until social security disability benefits are awarded or until the individual is denied either disability benefits or consideration by the appeals council.

(2) The individual has reapplied for social security disability benefits and establishes by credible, competent medical evidence, as determined by the social security administration or by an entity designated by the social security administration or the state of Kansas to make such a determination, either that a new impairment exists or that the existing impairment has increased in severity since the individual originally applied for social security disability benefits. The individual may receive assistance until social security disability benefits are awarded or until the individual is denied either disability benefits or consideration by the appeals council.

(f) This regulation shall be effective on and after July 1, 2006. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c and K.S.A. 2005 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended, T-85-34, Dec. 19, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended, T-30-6-10-91, July 1, 1991; amended Oct. 28, 1991; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; amended Dec. 31, 1992; amended, T-30-2-15-93, Feb. 15, 1993; amended June 1, 1993; amended July 1, 1994; amended Jan. 1, 1997; amended March 1, 1997; amended Oct. 1, 1997; amended July 1,

2002; amended, T-30-5-27-04, July 1, 2004; amended Aug. 6, 2004; amended July 1, 2006.)

**30-4-90w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Dec. 30, 1994; amended Jan. 1, 1997; revoked March 1, 1997.)

**30-4-91.** (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended, T-87-15, July 1, 1986; amended, T-87-44, Jan. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; revoked, T-88-14, July 1, 1987; revoked May 1, 1988.)

**30-4-92 to 30-4-94. Reserved.**

**30-4-95. Eligibility factors specific to the non-FFP-FC program.** Each child shall meet the eligibility requirements set forth below to be eligible for the non-FFP-FC program. (a) A written order of commitment without guardianship shall have been issued giving the secretary care, custody, and control of the child.

(b) The child shall meet one of the following conditions:

(1) Is under the age of 18;

(2) Is under the age of 21 and a full-time student in a secondary school or equivalent level of vocational or technical training; or

(3) Is under the age of 21 and participating in an approved independent living plan.

(c) The child shall be ineligible for FFP-FC.

(d) The child shall be in need. The child's eligibility shall be determined on a calendar-month basis. Total budgetary requirements shall be compared with total applicable income. If there is a deficit, the child shall be determined to be in need if the child owns property with a value not in excess of allowable limits.

(e) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, and K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended Sept. 26, 1988; amended March 1, 1997.)

**30-4-96.** (Authorized by K.S.A. 1996 Supp.

39-708c; implementing K.S.A. 1996 Supp. 39-708c and K.S.A. 1996 Supp. 39-709 and K.S.A. 39-713d; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended April 1, 1990; amended Sept. 30, 1994; amended July 1, 1996; amended March 1, 1997; amended Oct. 1, 1997; revoked March 7, 2003.)

**30-4-97.** (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 1982 Supp. 39-708c, 39-709, K.S.A. 39-719b; effective May 1, 1981; amended, T-83-17, July 1, 1982; revoked, T-84-8, April 1, 1983; amended May 1, 1983; revoked, T-84-9, May 1, 1983; revoked May 1, 1984.)

**30-4-98. Funeral assistance (FA) program.** Assistance may be provided for funeral expenses upon the death of a recipient under the TAF, GA, or medical assistance program. (a) Funeral expenses. Funeral expenses shall include the cost of the following:

- (1)(A) The preparation of the body;
  - (B) a minimal casket;
  - (C) the transportation of the body within the trade area; and
  - (D) a service; or
  - (2) a cremation.
- (b) Application. Each request for funeral assistance shall be made within six months after either the date of death or the date on which the body is released by a county coroner.

(c) Treatment of resources.

(1) If a decedent, at the time of death, was not living with a child of the decedent who was under age 21, the spouse of the decedent, or an adult disabled child of the decedent, the total estate of the decedent shall be considered available. This provision shall not be applicable in situations in which there were separate living arrangements because of the need for institutional care. The estate shall not be allowed any exemptions.

(2) Eligibility for assistance shall be based on the assets owned by the family group at the time of decedent's death, under these circumstances:

(A) If, at the time of death, a decedent was living with a child of the decedent who was under age 21, the spouse of the decedent, or an adult disabled child of the decedent, or if the decedent was a child under age 21 living with the parent of the decedent; or

(B) if there were living arrangements separate from one of the persons specified in paragraph

(c)(2)(A) because of the need for institutional care.

(3) The total amount of proceeds on any life insurance policy on the decedent shall be considered available if the policy was owned by the decedent, the spouse of the decedent, or, if the decedent was a child under age 21, the parent of the decedent.

(4) Death benefits from SSA, VA, railroad retirement, KPERS, and any other burial funds shall be considered available.

(d) Resource limit. If the value of the resources considered available in accordance with subsection (c) does not exceed \$2,000, assistance may be provided.

If the resource value exceeds \$2,000, the decedent shall be ineligible for assistance.

(e) Assistance provided. If the decedent is eligible, the amount of funeral assistance provided shall be \$680, except that the total cost of funeral expenses, including the \$680 payment, shall not exceed \$2500. If the total cost exceeds \$2500, no assistance shall be provided.

This regulation shall be effective on and after January 1, 2008. (Authorized by and implementing K.S.A. 39-708c and K.S.A. 39-713d; effective Aug. 11, 2006; amended Jan. 1, 2008.)

#### **30-4-99. Reserved.**

**30-4-100. Payment standards for budgetary requirements in the TAF, GA, and foster care programs.** The basic and shelter standards contained in K.A.R. 30-4-101 and 30-4-102, and the designated special requirements set forth in K.A.R. 30-4-120, shall be used in determining total budgetary requirements for the TAF, GA, and foster care programs. An applicant or recipient shall not be eligible to have a standard included in the computation of the applicant's or recipient's budgetary requirements if the agency or another state's assistance program has issued the applicant or recipient a payment for the same maintenance items in the same calendar month. (a) TAF and foster care program budgeting shall be predicated upon the total number of persons in the assistance plan.

(1) The basic standard and 100% of the shelter standard shall be used under the following circumstances:

(A) All persons in the home are in the same assistance plan;

(B) The only person in the home not in the plan is an SSI recipient to whom the  $\frac{1}{3}$  SSI reduction



is applied because the person lives in the household and receives support and maintenance in kind;

(C) There is a bona fide commercial landlord-tenant relationship between the family group and the other persons in the home; or

(D) All persons in the plan are in a specialized living, commercial board and room, or commercial room-only living arrangement.

(2) The basic standard, plus a percentage reduction of the shelter standard, shall be used when there are one or more persons residing in the home who are not included in the assistance plan, except as set forth in paragraphs (B), (C), and (D) above. The percentage reduction shall be as follows:

(A) 60% reduction for one person in the plan;

(B) 50% reduction for two persons in the plan;

(C) 40% reduction for three persons in the plan;

(D) 35% reduction for four persons in the plan;

(E) 30% reduction for five persons in the plan; and

(F) 20% reduction for six or more persons in the plan.

(b) GA program budgeting. Budgeting shall be predicated upon the total number of persons in the household. For purposes of budgeting, a "household" means one or more persons living as an economic unit and sharing in any of the maintenance items included in the basic standard or shelter standard.

(1) The budgetary standards, excluding the amount designated as an energy supplement, for each applicant or recipient shall equal 80% of the total budgetary requirements except for the following individuals:

(A) Any person receiving care or supervision;

(B) Any person who is participating in vocational rehabilitation program training; and

(C) Any person residing in specialized living arrangements.

(2) The basic and shelter standards shall be used for each person living alone, maintaining a separate household, or residing in a specialized living, commercial board and room, or commercial room-only living arrangement.

(3) For each person residing in a living arrangement other than that specified in paragraph (2) above, the basic and shelter standards shall be computed as follows:

(A) The standards set forth in K.A.R. 30-4-101 shall be used to determine the basic and shelter

standards for the number of persons in the household, to a maximum of four persons.

(B) The applicable standard shall be divided by the number of persons in the household, to a maximum four persons. The result shall be multiplied by the number of persons in the assistance plan to establish the basic and shelter standards.

(c) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, T-84-8, April 1, 1983; amended May 1, 1983; amended, T-84-9, May 1, 1983; amended May 1, 1984; amended, T-86-19, July 1, 1985; amended May 1, 1986; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended July 1, 1989; amended March 1, 1997.)

**30-4-100w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 359, Section 1; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-101. Standards for persons in own home, other family home, specialized living, commercial board and room, or commercial room-only living arrangements.** A monetary standard shall be deemed to address the costs of day-to-day expenses and certain special expenditures. (a) Basic standard. The basic standards shall be those set forth below. The basic standards include \$18.00 per person as an energy supplement.

**PERSONS IN PLAN**

1	2	3	4
\$132.00	\$217.00	\$294.00	\$362.00

For each additional person, add \$61.00.

(b) Shelter standard. A standard has been established for shelter based on location in the state. The shelter standards shall be those set forth below for each county.

Standard.	Group I \$92.00		
Allen	Bourbon	Cheyenne	
Anderson	Brown	Clark	
Atchison	Chase	Clay	
Barber	Chautauqua	Cloud	
Barton	Cherokee	Coffey	

Standard.	<b>Group I \$92.00</b>		
	Comanche	Jewell	Pratt
	Cowley	Kearny	Rawlins
	Crawford	Kingman	Republic
	Decatur	Labette	Rooks
	Dickinson	Lane	Rush
	Doniphan	Lincoln	Russell
	Edwards	Linn	Saline
	Elk	Logan	Scott
	Ellis	Lyon	Sheridan
	Ellsworth	Marion	Smith
	Finney	Marshall	Stafford
	Ford	Meade	Stanton
	Geary	Mitchell	Stevens
	Gove	Montgomery	Sumner
	Graham	Morris	Thomas
	Grant	Nemaha	Trego
	Greeley	Neosho	Wabaunsee
	Greenwood	Ness	Wallace
	Hamilton	Norton	Washington
	Harper	Osborne	Wichita
	Haskell	Ottawa	Wilson
	Hodgeman	Phillips	Woodson
	Jackson	Pottawatomie	
Standard.	<b>Group II \$97.00</b>	<b>Group III \$109.00</b>	<b>Group IV \$135.00</b>
	Franklin	Butler	Douglas
	Gray	Jefferson	Harvey
	Kiowa	Leavenworth	Johnson
	Morton	McPherson	
	Pawnee	Miami	
	Seward	Osage	
	Sherman	Reno	
		Rice	
		Riley	
		Sedgwick	
		Shawnee	
		Wyandotte	

(c) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Chapter 229, Section 104; implementing K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-85-19, July 1, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended, T-86-42, Jan. 1, 1986; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-88-2, Feb. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-5-1-90, May 1, 1990; amended, T-

30-8-28-90, Aug. 30, 1990; amended, T-30-12-28-90, Dec. 28, 1990; amended April 1, 1991; amended, T-30-6-10-91, July 1, 1991; amended Oct. 28, 1991; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; amended Oct. 13, 1995; amended March 1, 1997.)

**30-4-102. Standards for children in foster care.** The standards below shall be used for children in foster care. (a) The cost of care for any child placed in a care facility shall be an amount established by the secretary.

(b) The foster care standards shall also be used to meet the maintenance needs of a child of a foster care recipient if the recipient and the child are living together in the same foster care living arrangement.

(c) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 39-708c, amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended, T-84-8, April 1, 1983; amended, T-84-9, May 1, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-19, July 1, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended, T-86-42, Dec. 18, 1985; amended May 1, 1986; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended, T-30-2-28-90, Jan. 2, 1990; amended May 1, 1990; amended March 1, 1997.)

**30-4-103 and 30-4-104. Reserved.**

**30-4-105.** This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 1982 Supp. 39-708c, 39-709; effective May 1, 1981; amended May 1, 1983; revoked March 1, 1997.)

**30-4-105w.** This rule and regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Sections 5, 8, and 13; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-106. General rules for consideration of resources, including real property, personal property, and income.** (a) For purposes of determining eligibility for assistance,

ownership of property shall be determined by legal title. In the absence of a legal title, ownership shall be determined by possession.

(b) Resources, to be real, shall be of a nature that the value can be defined and measured. The value of resources shall be established by the objective measurements set forth in paragraphs (1) and (2) below.

(1) Real property. The value of real property shall be initially determined by the latest uniform statewide appraisal value of the property, which shall be adjusted to reflect current market value. If the property has not been appraised or if the market value as determined above is not satisfactory to the applicant or recipient or the agency, an estimate or appraisal of its value shall be obtained from a disinterested real estate broker. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(2) Personal property. The market value of personal property shall be initially determined by a reputable trade publication. If a publication is not available, or if there is a difference of opinion regarding the value of the property between the applicant or recipient and the agency, an estimate from a reputable dealer shall be used. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(c) Resources shall be considered available both when actually available and when the applicant or recipient has the legal ability to make them available. A resource shall be considered unavailable when there is a legal impediment that precludes the disposal of the resource. The applicant or recipient shall pursue reasonable steps to overcome the legal impediment unless it is determined that the cost of pursuing legal action would exceed the resource value of the property or that it is unlikely the applicant or recipient would succeed in the legal action.

(d) The resource value of property shall be that of the applicant's or recipient's equity in the property. Unless otherwise established, the proportionate share of jointly owned real property and the full value of jointly owned personal property shall be considered available to the applicant or recipient. Resources held jointly with a non-legally responsible person may be excluded from consideration if the applicant or recipient can demonstrate that the applicant or recipient has no ownership interest in the resource, that the applicant or recipient has not contributed to the resource, and that any access to the resource by the

applicant or recipient is limited to acting as an agent for the other person.

(e) Except as provided in subsection (h) and (l), non-exempt resources of all persons in the assistance plan and the nonexempt resources of persons who have been excluded from the assistance plan pursuant to K.A.R. 30-4-70(e)(3) and 30-4-90(a)(3) shall be considered.

(f) Except as provided in subsection (h), the combined resources of husband and wife, if they are living together, shall be considered in determining the eligibility of either or both for assistance, unless otherwise prohibited by law. A husband and wife shall be considered to be living together if they are regularly residing in the same household. Temporary absences of one of the couple for education or training, working, securing medical treatment, or visiting shall not be considered to interrupt the couple's living together.

(g) Despite subsections (e) and (f), the resources of an SSI beneficiary shall not be considered in the determination of eligibility for assistance of any other person, except for funeral assistance.

(h) The resources of an alien sponsor and the sponsor's spouse shall be considered in determining eligibility for the alien.

(i) A conversion of real or personal property from one form of a resource to another shall not be considered as income for the applicant or recipient except for the proceeds from a contract for the sale of property.

(j) Income shall not be considered both as income and as property in the same month.

(k) Despite subsection (e) above, the resources of a child whose needs are met through foster care payments shall not be considered.

(l) This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Jan. 1, 1988; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended March 1, 1997; amended Oct. 1, 1997.)

**30-4-106w.** This regulation shall be re-

voked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-107. Property exemption.** (a) Each assistance family may own otherwise nonexempt real or personal property with an aggregate resource value not in excess of \$2,000.00. Ownership of property with a resource value in excess of this amount shall render the assistance family group ineligible for assistance. However, if there is ineligibility due to excess real property, assistance shall be provided for a period of up to nine months if the applicant or recipient is making a bona fide and documented effort to dispose of the property.

(b) This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective May 1, 1981; amended May 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-33, Dec. 19, 1984; amended May 1, 1985; amended Oct. 1, 1997.)

**30-4-108. Real property.** (a) Definitions.

(1) "Home" means the house or shelter in which the applicant or recipient is living or from which the applicant or recipient is temporarily absent, as well as the tract of land and contiguous tracts of land upon which the house and other improvements essential to the use or enjoyment of the home or located. Tracts of land shall be considered to be contiguous if lying side by side, except for streets, alleys, or other easements. The home shall not include pieces of property that touch only at the corners.

(2) "Other real property" means any of the following types of property:

(A) real property other than a home;

(B) a home from which an applicant or recipient has been temporarily absent for at least 12 months; or

(C) a home to which an applicant or recipient will be unable to return.

(b) Treatment of real property. The equity value of non-exempt real property shall be considered as a resource.

(c) Exempted real property. The equity value of the following classifications of real property shall be exempt:

(1) The home;

(2) other real property that is essential for employment or self-employment; and

(3) other real property that is producing income consistent with its fair market value.

(d) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-19, Oct. 29, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1988; amended Sept. 26, 1988; amended March 1, 1997.)

**30-4-109. Personal property.** (a) Definitions.

(1) "Personal property" means all property, excluding real property.

(2) "Cash assets" means money, investments, cash surrender or loan values of life insurance policies, trust funds, and similar items on which a determinate amount of money can be realized.

(3) "Other personal property" means personal effects, household equipment and furnishings, home produce, livestock, equipment, vehicles, inventory, contracts from the sale of property, and similar items on which a determinate amount of money can be realized.

(b) Treatment of personal property. Personal property, unless exempted, shall be considered a resource.

(c) Exempted personal property. The resource value of the following classifications of personal property shall be exempt:

(1) Personal effects;

(2) household equipment and furnishings in use or only temporarily not in use;

(3) tools in use and necessary for the maintenance of house or garden;

(4) income-producing property, other than cash assets, that is essential for employment or self-employment or that is producing income consistent with its fair market value. Income-producing property may include tools, equipment, machinery, and livestock;

(5) the stock and inventory of any self-employed person that are reasonable and necessary in the production of goods or services;

(6) items for home consumption, which shall consist of the following:

(A) produce from a small garden consumed from day to day and any excess that may be canned or stored; and



(B) a small flock of fowl or livestock that is used to meet the food requirements of the family;

(7) one vehicle for each assistance family. Additional vehicles may be exempt if used over 50% of the time for employment or self-employment, if used as the family's home, or if specially equipped for use by a handicapped person;

(8) cash assets that are traceable to income exempted as income and as a cash asset;

(9) proceeds from the sale of a home if the proceeds are conserved for the purchase of a new home and the funds so conserved are expended or committed to be expended in the month received or in the following month;

(10) burial plots and funeral agreements that meet conditions established by the secretary of health and human services and approved by the secretary of social and rehabilitation services;

(11) any contract for the sale of property, if the proceeds from the contract are considered as income;

(12) escrow accounts established for families participating in the family self-sufficiency program through the department of housing and urban development. Interest earned on the accounts shall also be exempted as income; and

(13) the cash value of any life insurance policy.

(d) This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended Oct. 1, 1992; amended March 1, 1997; amended Oct. 1, 1997.)

**30-4-109w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 8; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-110. Income.** (a) Definitions.

(1) "Earned income" means income, in cash or in kind, that an applicant or recipient currently earns, through the receipt of wages, salary, or profit, from activities in which the individual engages as an employer or as an employee with responsibilities that necessitate continuing activity on the individual's part.

(2) "Unearned income" means all income not earned.

(3) "Lump sum" means a nonrecurring payment.

(b)(1) The following types of income shall be excluded from total income:

(A) Income-producing costs of the self-employed listed in K.A.R. 30-4-111(d);

(B) the income of a child received from a youth program funded by the job training partnership act of 1982, as specified in K.A.R. 30-4-113(i); and

(C) the earned income of a child as defined in K.A.R. 30-4-70(a)(2) who is a student in elementary or secondary school or who is working towards attainment of a G.E.D.

(2) For purposes of this regulation, total income shall be regarded as the sum of all earned income, or adjusted gross income of the self-employed, with no exemptions, all nonexempt, unearned income and nonexempt, current support payments received and reported by the child support enforcement office.

(c) Treatment of income.

(1) A prospective or income-average budgetary method shall be used to determine eligibility and the amount of the assistance payment for persons with income.

(2) Prospective budgeting shall be used to determine initial eligibility and the amount of the assistance payment in each calendar month. The budget estimate shall reflect the income received and the income expected to be received.

(3) Intermittent income or income from self-employment shall be considered and averaged. Intermittent income shall be divided by the proper number of months to establish the monthly amount. For self-employed persons with monthly income, the income average shall be based on the income earned during two or more representative months.

(d) This regulation shall be effective on and after October 1, 2003. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended March

1, 1997; amended July 1, 1997; amended July 1, 1998; amended Oct. 1, 2003.)

**30-4-110w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-111. Applicable income.** (a) “Applicable income” means the amount of earned and unearned income to be subtracted from the budgetary requirements in determining the budgetary deficit.

(b) Applicable earned income for persons included in the assistance plan shall equal gross earned income or the adjusted gross earned income from self-employment, less the following items:

- (1) Ninety dollars for each employed person;
- (2) the earned income disregard of 40 percent of the remaining income, for the following persons in a TAF or foster care assistance plan:

(A) Each applicant who had received assistance in one of the four preceding months; and

(B) each recipient; and

(3) reasonable expenses for child care or expenses for the care of an incapacitated person. The amount of deductible dependent care shall not exceed \$200.00 per month per person for persons under age two or \$175.00 per month per person for persons age two or older. The dependent shall be included in the family group before the deduction is allowed.

(c) For self-employed persons, adjusted gross earned income shall equal gross earned income less costs of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income. A standard deduction of 25% of gross earned income shall be allowed for these costs. If the person wishes to claim actual costs incurred, the following guidelines shall be used by the agency in calculating the cost of the production of the income.

(1) The public assistance program shall not be used to pay debts, set up an individual in business, subsidize a nonprofit activity, or treat income on the basis of internal revenue service (IRS) policies.

(2) If losses are suffered from self-employment, the losses shall not be deducted from other income, nor may a net loss of a business be considered an income-producing cost.

(3) If a business is being conducted from a lo-

cation other than the applicant’s or recipient’s home, the expenses for business space and utilities shall be considered income-producing costs.

(4) If a business is being conducted from a person’s own home, shelter and utility costs shall not be considered income-producing costs unless they are clearly distinguishable from the operation of the home.

(5) If payments increase the equity in equipment, vehicles, or other property, the payments shall not be considered income-producing costs.

(6) If equipment, vehicles, or other property are being purchased on an installment plan, the actual interest paid may be considered an income-producing cost.

(7) Depreciation on equipment, vehicles, or other property shall not be considered an income-producing cost.

(8) Insurance payments on equipment, vehicles, or other property shall be allowed if the payments directly relate to the business.

(9) Expenses for inventories and supplies that are reasonable and required for the business shall be considered income-producing costs.

(10) Wages and other mandated costs related to wages paid by the applicant or recipient shall be considered income-producing costs.

(d) The applicable income for a person in the home whose income is required to be considered and who is not included in the assistance plan shall equal all nonexempt, unearned income and gross earnings, or adjusted gross earnings of the self-employed, without the application of any income disregards, unless otherwise prohibited by law.

(e) The income of an alien’s sponsor and the sponsor’s spouse shall be considered in determining eligibility and the amount of the assistance payment for the alien.

(f) All net unearned income of persons included in the assistance plan shall be applicable unless exempted. Net unearned income shall equal gross unearned income less the costs of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income. The principles set forth in subsection (c) of this regulation regarding the calculation of income-producing costs shall be applicable.

(g) This regulation shall take effect on and after January 1, 1999. (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 1997 Supp. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May

1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Oct. 1, 1989; amended Jan. 2, 1990; amended May 1, 1991; amended, T-30-11-16-93, Dec. 1, 1993; amended Jan. 3, 1994; amended March 1, 1997; amended July 1, 1997; amended July 1, 1998; amended Jan. 1, 1999.)

**30-4-111w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 13; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-112. Income exempt from consideration as income and as a cash asset.** The following income shall be exempt, except as provided in K.A.R. 30-4-110(b):

(a) Grants and scholarships provided for educational purposes;

(b) the value of benefits provided under the food stamp program;

(c) the value of the U.S. department of agriculture donated foods;

(d) the value of supplemental food assistance received under the child nutrition act of 1966, as amended, and the special food service program for children under the national school lunch act, as amended;

(e) benefits received under title V, community services employment program, or title VII, nutrition program for the elderly, of the older Americans act of 1965, as amended;

(f) Indian funds distributed or held in trust, including interest and investment income accrued on such funds while held in trust and initial purchases made with such funds;

(g) distributions to natives under the Alaska native claims settlement act;

(h) payments provided to individual volunteers serving as foster grandparents, senior health aides, and senior companions, and to persons serving in the service corps of retired executives and active corps of executives under titles II and III of the domestic service act of 1973;

(i) payments to individual volunteers under title I, sec. 404(g) of Public Law 93-113 when the director of ACTION determines that the value of such payments, adjusted to reflect the number of

hours such volunteers are serving, is less than the federal minimum wage;

(j) payments received under the uniform relocation assistance and real property acquisition policies act of 1970;

(k) death benefits from SSA, VA, railroad retirement, or other burial insurance policy when the benefit is used toward the cost of burial;

(l) a one-time payment or a portion of a one-time payment from a cash settlement for repair or replacement of property or for legal services, or medical costs or other required obligations to a third party, if the payment is expended or committed to be expended for the intended purpose within six months of its receipt;

(m) money that VA determines may not be used for subsistence needs held in trust by VA for a child;

(n) retroactive corrective assistance payments in the month received or in the following month;

(o) income directly provided by vocational rehabilitation;

(p) benefits from special government programs at the discretion of the secretary, including energy assistance programs.

(q) cash donations that are based on need, do not exceed \$300 in any calendar quarter, and are received from one or more private, nonprofit, charitable organizations;

(r) reimbursements for out-of-pocket expenses in the month received and the following month;

(s) proceeds from any bona fide loan requiring repayment;

(t) payments granted to certain U.S. citizens of Japanese ancestry and resident Japanese aliens under Title I of Public Law 100-383;

(u) payments granted to certain Aleuts under Title II of Public Law 100-383;

(v) agent orange settlement payments;

(w) foster care and adoption support payments;

(x) the amount of any earned income tax credit received. Such credit shall not be regarded as a cash asset in the month of receipt and the following month;

(y) federal major disaster and emergency assistance and comparable disaster assistance provided by state or local government or by disaster assistance organizations in conjunction with a presidentially declared disaster;

(z) payments granted to the Aroostook Band of Micmac Indians under Public Law 102-171;

(aa) payments from the radiation exposure

compensation trust fund made by the department of justice; and

(bb) special federal allowances paid monthly to children of Vietnam veterans who are born with spina bifida.

This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended May 1, 1991; amended July 1, 1991; amended Jan. 2, 1992; amended Oct. 1, 1992; amended Oct. 1, 1993; amended Dec. 30, 1994; amended Oct. 1, 1997.)

**30-4-112w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 5; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-113. Income exempt as applicable income.** The following types of income shall be exempt as applicable income in the determination of the budgetary deficit: (a) earned income of a child who is under the age of 19 years if the child is a student in elementary or secondary school or is working towards attainment of a G.E.D.

(b) lump sum income;

(c) irregular, occasional, or unpredictable monetary gifts that do not exceed \$50.00 per month per family group;

(d) income-in-kind;

(e) shelter cost participation payments. In shared living arrangements in which two families contribute toward the shelter obligations, any cash paid toward the shared shelter obligation by one family to the second family in the shared arrangement shall not be considered as income to the second family. This exemption shall not be applicable in a bona fide, commercial landlord-tenant arrangement;

(f) tax refunds and rebates, except for earned income tax credits in accordance with K.A.R. 30-4-112(y);

(g) incentive payments received by renal dialysis patients;

(h) home energy assistance furnished on the basis of need by a federally regulated or state-regulated entity whose revenues are primarily derived on a rate-of-return basis, by a private, non-profit organization, by a supplier of home heating oil or gas, or by a municipal utility company that provides home energy;

(i) income received from the job training partnership act of 1982. However, earnings received by individuals who are participating in on-the-job training programs shall be countable unless the individual is a child;

(j) housing assistance from federal housing programs;

(k) assistance payments in the month received;

(l) support payments received following the effective date of the assignment of support rights to the agency. However, a support refund disbursed by the agency to the recipient or reported current support that, if prospectively treated as nonexempt income, would result in ineligibility, shall not be exempt income;

(m) up to \$2,000.00 per year of income received by an individual Indian that is derived from leases or other uses of an individually owned trust or restricted lands;

(n) veterans administration (VA) aid and attendance and housebound allowances;

(o) VA payments resulting from unusual medical expenses;

(p) interest income that does not exceed \$50.00 per month per family group;

(q) the amount of any child support pass through payment; and

(r) the amount of any child support arrearage payment.

This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended May 1, 1991; amended July 1, 1991; amended Sept. 30, 1994; amended Dec. 30, 1994; amended March 1, 1997; amended July 1, 1997; amended Oct. 1, 1997.)



**30-4-113w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-114 to 30-4-119. Reserved.**

**30-4-120. Special needs for applicants and recipients of TAF.** (a) The expenses for the following special needs shall be added to the basic and shelter standards as outlined in K.A.R. 30-4-100 to compute the budgetary requirements for applicants and recipients under the conditions as specified.

(1) Temporary out-of-home care for children. The cost of temporary, out-of-home care may be allowed under the following conditions:

(A) The child is temporarily absent from the home due to the illness of another member of the household or the incarceration of the caretaker relative;

(B) the temporary absence is only for a portion of a calendar month; and

(C) there is an approved service plan. The amount to be allowed shall be the foster care standard.

(2) Conservator or personal representative expense. The fee of the legally appointed conservator for conservatorship or the personal representative fee for service shall be allowed under the following conditions:

(A) The conservator or personal representative charges for those services; and

(B) the conservator or personal representative is not the spouse, parent, or child of the incapacitated person. The amount allowed by the court, or the conservator's or personal representative's charge, shall be allowed to a maximum of five percent of the person's cash payment or \$8.00, whichever is greater.

(3) Special household and childrearing expenses. Costs for special household and childrearing expenses may be allowed in an amount that does not exceed the highest allowable basic and shelter standard, as outlined in K.A.R. 30-4-100. Payment for these expenses shall be derived from donor funds that are earmarked for the family or otherwise designated to the family by a donor. The following expenses may be covered under this provision:

(A) Repair or replacement of household items;

(B) replacement of essential clothing;

(C) special needs related to pregnancy or newborn child;

(D) special school expenses for children; and  
(E) other essential household expenses or expenses resulting from a catastrophe.

(b) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-33, Dec. 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Oct. 1, 1989; amended, T-30-3-29-90, April 1, 1990; amended, T-30-7-2-90, Aug. 1, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991; amended May 1, 1991; amended Aug. 1, 1995; amended Jan. 1, 1997; amended March 1, 1997.)

**30-4-120w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Dec. 30, 1994; amended August 1, 1995; amended Jan. 1, 1997; revoked March 1, 1997.)

**30-4-121.** This regulation shall be revoked on and after July 1, 1996. (Authorized by K.S.A. 1983 Supp. 39-708c; implementing K.S.A. 1983 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-84-30, Nov. 2, 1983; amended May 1, 1984; revoked July 1, 1996.)

**30-4-122.** (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 39-719b, K.S.A. 1982 Supp. 39-708c, 39-709; effective May 1, 1981; amended, T-83-9, April 29, 1982; revoked May 1, 1983.)

**30-4-122a.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c, implementing K.S.A. 1992 Supp. 39-708c, 39-709, as amended by 1993 SB 317; effective, T-84-9, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended June 1, 1993; amended, T-30-9-16-93,

Sept. 16, 1993; amended Nov. 8, 1993; revoked March 1, 1997.)

**30-4-123.** (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 1982 Supp. 39-708c, 39-709, K.S.A. 19-1015, 39-719b; effective May 1, 1981; amended, T-83-17, July 1, 1982; revoked, T-84-8, April 1, 1983; amended May 1, 1983; revoked, T-84-9, May 1, 1983; revoked May 1, 1984.)

**30-4-124 to 30-4-129. Reserved.**

**30-4-130. Types of payments.** Public assistance payments shall be issued in accordance with the provisions set forth below. (a) Money payment. Payments shall be available through the state electronic benefit transfer system or, in certain circumstances, by check or warrant immediately redeemable at par. Payments shall be made with no restriction on the use of the funds. All payments shall be money payments, except for the following types of payments:

- (1) Payments pursuant to the foster care programs;
- (2) work program support costs and transitional expenses in accordance with K.A.R. 30-4-64 (c) and (d);
- (3) protective payments; and
- (4) subsistence allowances for GA clients residing in specialized living arrangements in which there is a current approved provider agreement with the secretary.

(b) Who may receive money payments. The following persons may receive money payments:

- (1) a caretaker;
- (2) a recipient;
- (3) a personal representative; or
- (4) substitute payee.

A minor shall not receive a money payment unless emancipated.

(c) Protective payments in the TAF and GA programs.

(1) If any caretaker persistently mismanages the money payment to the detriment of any child for whom assistance is claimed and if an approved service plan is on file, a protective payment, in lieu of a money payment to the caretaker, shall be issued to a substitute payee.

(2) If a substitute payee is unavailable, a protective vendor payment shall be issued.

(3) If the caretaker has been removed and all reasonable efforts to identify a suitable protective

payee have failed, protective payments shall not be required.

(d) Substitute payee.

(1) Appointment and dismissal. Each substitute payee shall be appointed as assisted by the agency. The payee may be terminated by the agency if the payee's services are no longer needed or if the payee is not giving satisfactory service. A payee shall be removed only after a careful evaluation of the payee's performance has been made.

(2) (A) Who may be substitute payee. An individual selected to be a substitute payee may be a relative, friend, neighbor, or member of a religious or community organization. The following persons shall not serve as substitute payees:

- (i) the agency's area director;
- (ii) the supervisor of the agency worker;
- (iii) the agency's worker determining financial eligibility;
- (iv) the agency's special investigative or resource staff;
- (v) the staff handling the fiscal process for the client; or
- (vi) the landlord, grocers, or vendors of goods or services dealing directly with the client.

(B) Exception. Payments may be made to a foster parent on behalf of a minor living in a foster care home with the minor's child in order to provide TAF for the child. Such a foster care home shall be licensed or approved as meeting licensing standards. This provision shall not be used in any other kind of public assistance case and may continue until the minor is released from custody of the agency or becomes emancipated.

(3) Criteria for selection. Each substitute payee shall demonstrate the following characteristics:

(A) An interest and concern for the welfare of the family;

(B) the ability to help the family with ordinary budgeting, experience in purchasing food, clothing and household equipment within a limited income, and knowledge of effective household practices;

(C) the ability to establish and maintain a positive relationship;

(D) the ability to maintain close contacts with the caretaker and child by virtue of living near the caretaker or having transportation available; and

(E) responsibility and dependability.

(4) Payee-recipient relationship. Each payee may make decisions about the expenditure of the

assistance payment. The payee may expend the payment in any of the following ways:

- (A) spend the money for the family;
- (B) supervise the recipient's use of the money;

or

(C) give a portion of the money to the recipient to spend for certain expenses and pay for other expenses of the recipient.

(5) Payee-agency relationship. Each payee shall assure the agency that the money is spent for the children's benefit. The payee's responsibility to the agency shall be set forth in writing with one copy for the payee and one for the agency.

(A) This written agreement shall cover the following areas:

- (i) the plans for accounting;
- (ii) use of the assistance funds; and
- (iii) reporting on the general progress made.

(B) The agreement shall be supplemented by the following:

- (i) discussions of the payee's responsibility;
- (ii) a statement of the purpose of the plan;
- (iii) a description of the nature and frequency of reports;
- (iv) a statement of the rights of the recipient; and
- (v) a statement of the confidential nature of the relationship.

(6) Periodic review of cases. Each money payment mismanagement case shall be reviewed at least every six months to determine which of the following actions will be taken:

(A) Restore the recipient to regular money payment status;

(B) continue the recipient on protective payment status; or

(C) develop another plan for the care of the child or children if necessary, including any of the following options:

- (i) placement with another relative;
- (ii) seeking appointment of a guardian; or
- (iii) placement in a foster home.

(7) Discontinuance of protective payments. Protected payments shall be discontinued when the caretaker has demonstrated an ability to manage the money payment or after a period of two years has lapsed, whichever comes first. Payment may continue for any additional time reasonably necessary to complete a substitute plan for the care of the child.

(e) Special personal representative. A petition for the appointment of a personal representative shall be filed by the agency only if the need for an

appointment is clearly established, and the agency has counseled with the applicant or recipient concerning the money management problems. Confidential reports shall be filed by the agency with the appropriate court as requested.

(1) Appointment of personal representative. A person who meets the following qualifications shall be recommended to the court as a personal representative by the agency.

(A) The person shall not be an employee of the agency.

(B) The person shall not benefit directly from the assistance payment.

(C) The person shall meet the criteria set forth in paragraph (d)(2)(A) of this regulation.

(2) Dismissal of personal representative. A recommendation to the court to dismiss a personal representative shall be made by the agency if the client demonstrates that the client no longer requires a personal representative, or if the personal representative is failing to execute the responsibilities set forth in this regulation, in which instance a substitute personal representative shall be recommended by the agency.

(3) Responsibility of personal representative. Each personal representative shall be responsible to the court, the agency, and the recipient. Each personal representative shall make an annual accounting to both the court and the agency. A more frequent accounting may be required by the agency or the court in the form and at the times prescribed by the agency or the court. Each personal representative shall maintain a confidential relationship with the applicant or recipient and shall consult with the applicant or recipient concerning the applicant's or recipient's requirements, resources, and the use of the money payment.

(4) Periodic review. The necessity of continuing the appointment of a personal representative shall be reviewed semiannually. Consideration shall be given to whether or not the recipient's ability to manage personal affairs has improved or if other changes in the recipient's circumstances or living arrangements make it possible for the recipient to manage without the help of a personal representative.

(f) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 59-2801 *et seq.*, K.S.A. Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104 and K.S.A. 1995 Supp. 39-709; effective

May 1, 1981; amended May 1, 1983; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-6-10-91, July 1, 1991; amended Oct. 1, 1993; amended July 1, 1996; amended March 1, 1997.)

**30-4-130w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 39-708c; implementing K.S.A. 59-2801 et seq., K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-4-131 to 30-4-139. Reserved.**

**30-4-140. Payments.** (a) Payment amounts. Assistance payments shall equal the budgetary deficit, which shall be rounded down to the nearest dollar, except as set forth below.

(1) Payments for the month of application shall equal the budgetary deficit, which shall be prorated beginning with the date of application through the end of the month. This amount shall be rounded down to the nearest dollar.

(2) A payment shall not be made if the amount of the budgetary deficit is less than \$10.00. When a payment is not made under this provision, recipient status shall continue.

(b) Underpayments. Underpayments shall be promptly corrected.

(c) Overpayments. Overpayments shall be promptly corrected. Recovery procedures shall not be initiated by the agency, pending the disposition of a welfare fraud referral. Overpayments may be recovered by voluntary repayment, administrative recoupment, or legal action. The assistance payment shall be reduced for recoupment as follows:

(1) For fraud claims, by the greater of 20% of the applicable need standard or \$10.00 per month; and

(2) for non-fraud claims, by the greater of 10% of the applicable need standard or \$10.00 per month.

(d) Disqualification penalties.

(1) Each individual who is found to have committed fraud, either through an administrative disqualification hearing or by a court of appropriate jurisdiction, or who has signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in any

case referred for prosecution, shall be ineligible for assistance as set forth below.

(A) If the individual is found to have made a fraudulent statement or representative with respect to the identity or place of residence of the individual in order to receive multiple benefits simultaneously, the individual shall be ineligible for a period of 10 years.

(B) For all other fraudulent acts, the individual shall be ineligible for one of the following periods of time:

- (i) 12 months for the first violation;
- (ii) 24 months for the second violation; and
- (iii) permanently for the third violation.

A court may impose an additional 18-month disqualification period for the first and second convictions on criminal cases only. If a court fails to impose a disqualification period, the disqualification periods outlined above shall be imposed, unless they are contrary to the court order.

(2) Upon determination of fraud, an applicant shall be denied assistance. A recipient shall be terminated from assistance no later than the first day of the second month following the month the notice of disqualification is sent.

(e) Discontinuance of assistance payments. Assistance payments shall be discontinued when the recipient no longer meets one or more of the appropriate eligibility factors.

(f) This regulation shall take effect on and after July 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 39-719b, K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended, T-83-38, Nov. 23, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended July 1, 1989; amended May 1, 1992; amended March 1, 1997; amended July 1, 1998.)

**30-4-140w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-719b and 39-708c; effective Dec. 30, 1994; amended August 1, 1995; revoked March 1, 1997.)

**Article 5.—PROVIDER PARTICIPATION,  
SCOPE OF SERVICES, AND  
REIMBURSEMENTS FOR THE  
MEDICAID (MEDICAL ASSISTANCE)  
PROGRAM**

**30-5-1.** (Authorized by K.S.A. 39-709, K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967;



amended Jan. 1, 1968; amended Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-5-2.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; amended, E-71-34, Aug. 11, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-5-3.** (Authorized by K.S.A. 1969 Supp. 39-708; effective Jan. 1, 1967; amended, E-70-9, Dec. 4, 1969; revoked Jan. 1, 1971.)

**30-5-4 to 30-5-9.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1971.)

**30-5-10.** (Authorized by K.S.A. 1967 Supp. 39-708; effective Jan. 1, 1967; amended Jan. 1, 1968; revoked Jan. 1, 1971.)

**30-5-11 and 30-5-12.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1971.)

**30-5-13.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1971; amended Jan. 1, 1973; amended Jan. 1, 1974; amended, E-76-10, Jan. 23, 1975; amended May 1, 1975; revoked May 1, 1976.)

**30-5-14.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1969; revoked May 1, 1976.)

**30-5-15.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-5-16.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1969; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

**30-5-17.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; revoked May 1, 1976.)

**30-5-18.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; revoked May 1, 1976.)

**30-5-19.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1,

1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended, E-72-3, Nov. 5, 1971; amended Jan. 1, 1972; amended, E-72-12, March 31, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-5-20.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended, E-72-3, Nov. 5, 1971; amended Jan. 1, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-5-21.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended, E-77-36, July 1, 1976; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-5-22.** (Authorized by K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; revoked, E-72-23, July 28, 1972; revoked Jan. 1, 1973.)

**30-5-23.** (Authorized by K.S.A. 1978 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; revoked, E-79-20, Aug. 17, 1978; revoked May 1, 1979.)

**30-5-24.** (Authorized by K.S.A. 1976 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; revoked Feb. 15, 1977.)

**30-5-25.** (Authorized by K.S.A. 1980 Supp.

39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

**30-5-26.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-70-9, Dec. 4, 1969; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended, E-77-36, July 1, 1976; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-5-27.** (Authorized by K.S.A. 1971 Supp. 39-708; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; revoked, E-72-23, July 28, 1972; revoked Jan. 1, 1973.)

**30-5-28.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1974; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-5-29.** (Authorized by K.S.A. 1970 Supp. 39-708; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; revoked Jan. 1, 1974.)

**30-5-30.** (Authorized by K.S.A. 1970 Supp. 39-708; effective Jan. 1, 1967; revoked, E-70-9, Dec. 4, 1969; revoked Jan. 1, 1971.)

**30-5-31.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended, E-72-3, Nov. 5, 1971; amended Jan. 1, 1972; amended, E-72-12, March 31, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended, E-79-30, Nov. 21, 1978; amended May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-5-32.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972;

amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended, E-79-30, Nov. 21, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-5-33.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-5-34.** (Authorized by K.S.A. 1980 Supp. 39-708c, 75-3304; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended, E-72-3, Nov. 5, 1971; amended, E-72-12, March 31, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-5-35.** (Authorized by K.S.A. 1970 Supp. 39-708; effective Jan. 1, 1969; revoked, E-70-9, Dec. 4, 1969; revoked Jan. 1, 1971.)

**30-5-36.** (Authorized by K.S.A. 75-5321; effective Jan. 1, 1974; revoked May 1, 1981.)

**30-5-37 and 30-5-38.** (Authorized by K.S.A. 75-5321, 75-5375(s), K.S.A. 1980 Supp. 39-708c, 39-748; effective, E-78-19, July 8, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-5-39.** (Authorized by K.S.A. 75-5321, K.S.A. 1980 Supp. 39-708c, 39-748; effective, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-5-40.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-78-19, July 8, 1977; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-5-41.** (Authorized by K.S.A. 75-5321, 75-5375(s), K.S.A. 1980 Supp. 39-708c, 39-748;

effective, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

**30-5-42.** (Authorized by K.S.A. 75-5321, K.S.A. 1980 Supp. 39-708c, 39-748; effective, E-79-1, Feb. 1, 1978; effective May 1, 1978; revoked May 1, 1981.)

**30-5-43.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-5-44.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-33, Dec. 20, 1978; effective May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-5-45.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-5-46.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-5-47.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-5-48 to 30-5-50.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective May 1, 1980; revoked May 1, 1981.)

**30-5-51 to 30-5-54. Reserved.**

**30-5-55 to 30-5-57.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-80-13, Aug. 8, 1979; effective May 1, 1980; revoked May 1, 1981.)

**30-5-58. Definitions.** The following words and terms, when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

provider will accept the medicare-allowed payment rate as payment in full for services provided to a recipient.

(b) "Accrual basis accounting" means that revenue of the provider is reported in the period in which it is earned, regardless of when it is col-

lected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(c) "Acquisition cost" means the allowable reimbursement price for each covered drug, supply, or device as determined by the secretary in accordance with federal regulations.

(d) "Admission" means entry into a hospital for the purpose of receiving inpatient medical treatment.

(e) "Agency" means the department of social and rehabilitation services.

(f) "Ambulance" means a state-licensed vehicle equipped for emergency transportation of injured or sick recipients to facilities where medical services are rendered.

(g) "Arm's-length transaction" means a transaction between unrelated parties.

(h) "Border cities" means those communities outside of the state of Kansas but within a 50-mile range of the state border.

(i) "Capitated managed care" means a type of managed care plan that uses a risk-sharing reimbursement method whereby providers receive fixed periodic payments for health services rendered to plan members. Capitated fees shall be set by contract with providers and shall be paid on a per person basis regardless of the amount of services rendered or costs incurred.

(j) "Capitation reimbursement" means a reimbursement methodology establishing payment rates, per program consumer or eligible individual, for a designated group of services.

(k) "Case conference" means a scheduled, face-to-face meeting involving two or more persons to discuss problems associated with the treatment of the facility's patient or patients. Persons involved in the case conference may include treatment staff, or other department representatives of the client or clients.

(l) "Change of ownership" means a change that involves the following:

(1) An arm's-length transaction between unrelated parties; and

(2) (A) The dissolution or creation of a partnership when no member of the dissolved partnership or the new partnership retains ownership interest from the previous ownership affiliation;

(B) a transfer of title and property to another party if the property is owned by a sole proprietor;

(C) the change or creation of a new lessee acting as a provider of pharmacy services; or

(D) a consolidation of two or more corpora-

tions that creates a new corporate entity. The transfer of participating provider corporate stock shall not in itself constitute a change of ownership. A merger of one or more corporations with a participating provider corporation surviving shall not constitute a change of ownership.

(m) "Common control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(n) "Common ownership" means that an entity holds a minimum of five percent ownership or equity in the provider facility and in the company engaged in business with the provider facility.

(o) "Comparable outpatient service" means a service that is provided in a hospital and that is comparable to a service provided in a physician's office or ambulatory surgical center.

(p) "Concurrent care" means services rendered simultaneously by two or more eligible providers.

(q) "Consultation" means an evaluation that requires another examination by a provider of the same profession, a study of records, and a discussion of the case with the physician primarily responsible for the patient's care.

(r) "Contract loss" means the excess of contract cost over contract income.

(s) "Cost and other accounting information" means adequate data, including source documentation, that is accurate, current, and in sufficient detail to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if it originated at the time and near the place of the transaction. In order to provide the required cost data, financial and statistical records shall be maintained in a consistent manner. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedure.

(t) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(u) "Cost outlier" means a general hospital inpatient stay with an estimated cost that exceeds the cost outlier limit established for the respective diagnosis-related group.

(v) "Cost outlier limit" means the maximum cost of a general hospital inpatient stay established

according to a methodology specified by the secretary for each diagnosis-related group.

(w) "Cost-related reimbursement" means reimbursement based on analysis and consideration of the historical operating costs required to provide specified services.

(x) "Costs not related to patient care" means costs that are not appropriate, necessary, or proper in developing and maintaining the facility's operations and activities. These costs shall not be allowed in computing reimbursable costs under cost-related reimbursement.

(y) "Costs related to patient care" means all necessary and proper costs arising from arm's-length transactions in accordance with generally accepted accounting principles that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

(z) "Covered service" means a medical service for which reimbursement will be made by the medicaid/medikan program. Coverage may be limited by the secretary through prior authorization requirements.

(aa) "Day outlier" means a general hospital inpatient length of stay that exceeds the day outlier limit established for the respective diagnosis-related group.

(bb) "Day outlier limit" means the maximum general hospital inpatient length of stay established according to a methodology specified by the secretary for each diagnosis-related group.

(cc) "Diagnosis-related group" or "DRG" means the classification system that arranges medical diagnoses into mutually exclusive groups.

(dd) "Diagnosis-related group adjustment percent" or "DRG adjustment percent" means a percentage assigned by the secretary to a diagnosis-related group for purposes of computing reimbursement.

(ee) "Diagnosis-related group daily rate" or "DRG daily rate" means the dollar amount assigned by the secretary to a diagnosis-related group for purposes of computing reimbursement when a rate per day is required.

(ff) "Diagnosis-related group reimbursement system" or "DRG reimbursement system" means a reimbursement system in the Kansas medicaid/medikan program for general hospital inpatient services that uses diagnosis-related groups for determining reimbursement on a prospective basis.

(gg) "Diagnosis-related group weight" or "DRG weight" means the numeric value assigned



to a diagnosis-related group for purposes of computing reimbursement.

(hh) "Discharge" means release from a hospital. A discharge shall occur when the consumer leaves the hospital or dies. A transfer to another unit within a hospital, except to a swing bed, and a transfer to another hospital shall not be a discharge.

(ii) "Discharging hospital" means, in instances of the transfer of a consumer, the hospital that discharges the consumer admitted from the last transferring hospital.

(jj) "Dispensing fee" means the reimbursement rate assigned to each individual pharmacy provider for the provision of pharmacy services involved in dispensing a prescription.

(kk) "Disproportionate share hospital" means a hospital that has the following:

(1) Either a low-income utilization rate exceeding 25 percent or a medicaid/medikan hospital inpatient utilization rate of at least one standard deviation above the mean medicaid/medikan inpatient utilization rate for hospitals within the state borders of Kansas that are receiving medicaid/medikan payments; and

(2) at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to medicaid/medikan eligible individuals. In a hospital located in a rural area, the obstetrician may be any physician with staff privileges at the hospital who performs nonemergency obstetric procedures. The only exceptions to this requirement shall be the following:

(A) A hospital with inpatients who are predominantly under 18 years of age; or

(B) a hospital that did not offer nonemergency obstetric services as of December 21, 1987.

(ll) "Drug, supply, or device" means the following:

(1) Any article recognized in the official United States pharmacopoeia, another similar official compendium of the United States, an official national formulary, or any supplement of any of these publications;

(2) any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings;

(3) any article intended to affect the structure or any function of the bodies of human beings; and

(4) any article intended for use as a component of any article specified in paragraphs (1), (2), or (3) above.

(mm) "Durable medical equipment" or "DME" means equipment that meets these conditions:

(1) Withstands repeated use;

(2) is not generally useful to a person in the absence of an illness or injury;

(3) is primarily and customarily used to serve a medical purpose;

(4) is appropriate for use in the home; and

(5) is rented or purchased as determined by designees of the secretary.

(nn) "Election period" means the period of time for the receipt of hospice care, beginning with the first day of hospice care as provided in the election statement and continuing through any subsequent days.

(oo) "Election statement" means the revokable statement signed by a consumer that is filed with a particular hospice and that consists of the following:

(1) Identification of the hospice selected to provide care;

(2) acknowledgment that the consumer has been given a full explanation of hospice care;

(3) acknowledgment by the consumer that other medicaid services are waived;

(4) the effective date of the election period; and

(5) the consumer's signature or the signature of the consumer's legal representative.

(pp) "Emergency services" means those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Serious jeopardy to the patient's health;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(qq) "Estimated cost" means the cost of general hospital inpatient services provided to a consumer, as computed using a methodology set out in the Kansas medicaid state plan.

(rr) "Formulary" means a listing of drugs, supplies, or devices.

(ss) "Free-standing inpatient psychiatric facility" means an inpatient psychiatric facility licensed to provide services only to the mentally ill.

(tt) "General hospital" means an establishment that provides an organized medical staff of physicians, permanent facilities that include inpatient

beds, and medical services. The medical services provided by the hospital shall include the following:

- (1) Physician services;
- (2) continuous registered professional nursing services for 24 hours each day; and
- (3) diagnosis and treatment for nonrelated patients who have a variety of medical conditions.

(uu) "General hospital group" means the category to which a general hospital is assigned for purposes of computing reimbursement.

(vv) "General hospital inpatient beds" means the number of beds reported by a general hospital on the hospital and hospital health care complex cost report form, excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form, the number of beds shall be obtained from the provider application for participation in the Kansas medicaid/medikan program form.

(ww) "Generally accepted accounting procedures" means generally accepted accounting principles, except as otherwise specifically indicated by medicaid/medikan program policies and regulations. These principles shall not supersede any specific regulation or policy of the medicaid/medikan program.

(xx) "Group reimbursement rate" means the dollar value assigned by the secretary to each general hospital group for a diagnosis-related group weight of one.

(yy) "Health maintenance organization" means an organization of providers of designated medical services that makes available and provides these medical services to eligible enrolled individuals for a fixed periodic payment determined in advance and that limits referral to outside specialists.

(zz) "Historical cost" means actual allowable costs incurred for a specified period of time.

(aaa) "Hospice" means a public agency, private organization, or a subdivision of either, that primarily engages in providing care to terminally ill individuals, meets the medicare conditions of participation for hospices, and has enrolled to provide hospice services as provided in K.A.R. 30-5-59.

(bbb) "Hospital located in a rural area" means a facility located in an area outside of a metropolitan statistical area as defined in paragraph (sss).

(ccc) "Independent laboratory" means a laboratory that performs laboratory tests ordered by a

physician and that is in a location other than the physician's office or a hospital.

(ddd) "Ineligible provider" means a provider who is not enrolled in the medicaid/medikan program because of reasons set forth in K.A.R. 30-5-60, or because of commission of civil or criminal fraud in another state or another program.

(eee) "Interest expense" means the cost incurred for the use of borrowed funds on a loan made for a purpose related to patient care.

(fff) "Kan Be Healthy program participant" means an individual under the age of 21 who is eligible for medicaid, and who has undergone a Kan Be Healthy medical screening in accordance with a specified screening schedule. The medical screening shall be performed for the following purposes:

- (1) To ascertain physical and mental defects; and

- (2) to provide treatment that corrects or ameliorates defects and chronic conditions that are found.

(ggg) "Kan Be Healthy dental-only participant" means an individual under the age of 21 who is eligible for medicaid, and has undergone only a Kan Be Healthy dental screening in accordance with a specified screening schedule. The dental screening shall be performed for the following purposes:

- (1) To ascertain dental defects; and

- (2) to provide treatment that corrects or ameliorates dental defects and chronic dental conditions that are found.

(hhh) "Kan Be Healthy vision-only participant" means an individual under the age of 21 who is eligible for medicaid, and who has undergone only a Kan Be Healthy vision screening in accordance with a specified screening schedule. The vision screening shall be performed for the following purposes:

- (1) Ascertain vision defects; and

- (2) provide treatment that corrects or ameliorates vision defects and chronic vision conditions that are found.

(iii) "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.

(jjj) "Lock-in" means the restriction, through limitation of the use of the medical identification card to designated medical providers, of a con-

sumer's access to medical services because of abuse.

(kkk) "Low-income utilization rate for hospitals" means the rate that is defined in accordance with section 1923 of the social security act, codified at 42 U.S.C. 1396r-4, as amended by section 1(a)(6) of the consolidated appropriations act, 2001 P.L. 106-554, which enacted into law Section 701 of H.R. 5661, the medicare, medicaid, and SCHIP benefits improvement and protection act of 2000, effective December 21, 2000, which is adopted by reference.

(lll) "Managed care" means a system of managing and financing health care delivery to ensure that services provided to managed care plan members are necessary, efficiently provided, and appropriately priced.

(mmm) "Managerial capacity" means the authority of an individual, including a general manager, business manager, administrator or director, who performs the following functions:

(1) Exercises operational or managerial control over the provider; or

(2) directly or indirectly conducts the day-to-day operations of the provider.

(nnn) "Maternity center" means a facility licensed as a maternity hospital that provides delivery services for normal, uncomplicated pregnancies.

(ooo) (1) "Medical necessity" means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

(A) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.

(B) "Purpose." The health intervention has the purpose of treating a medical condition.

(C) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (ooo)(3). For existing interventions, effectiveness shall be determined as provided in paragraph (ooo)(4).

(E) "Value." The health intervention is cost-effective for this condition compared to alternative

interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

(2) The following definitions shall apply to these terms only as they are used in this subsection (ooo);

(A) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(B) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this regulation's definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

(D) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

(E) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

(F) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magni-

tude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

(G) "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.

(H) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

(I) "Treating physician" means a physician who has personally evaluated the patient.

(3) Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph (ooo)(4).

(4) The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

(ppp) "Medical necessity in psychiatric situations" means that there is medical documentation that indicates either of the following:

(1) The person could be harmful to himself or herself or others if not under psychiatric treatment; or

(2) the person is disoriented in time, place, or person.

(qqq) "Medical supplies" means items that meet these conditions:

(1) Are not generally useful to a person in the absence of illness or injury;

(2) are prescribed by a physician; and

(3) are used in the home and certain institutional settings.

(rrr) "Mental retardation" means any signifi-

cant limitation in present functioning that meets these requirements:

(1) Is manifested during the period of birth to age 18;

(2) is characterized by significantly subaverage intellectual functioning as reflected by a score of two or more standard deviations below the mean, as measured by a generally accepted, standardized, individual measure of general intellectual functioning; and

(3) exists concurrently with deficits in adaptive behavior, including related limitations in two or more of the following areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

(sss) "Metropolitan statistical area" or "MSA" means a geographic area designated as such by the United States executive office of management and budget as set out in the 64 Fed. Reg. 202, pp. 56628-56644, October 20, 1999, and 65 Fed. Reg. 249, pp. 82228-82238, December 27, 2000 which are adopted by reference.

(ttt) "Necessary interest" means interest expense incurred on a loan made to satisfy a financial need of the facility. A loan that results in excess funds or investments shall not be considered necessary.

(uuu) "Net cost" means the cost of approved educational activities, less any reimbursements from the following:

(1) Grants;

(2) tuition; and

(3) specific donations.

(vvv) "Non-covered services" means services for which medicaid/medikan will not provide reimbursement, including services that have been denied due to the lack of medical necessity.

(www) "Occupational therapy" means the provision of treatment by an occupational therapist registered with the American occupational therapy association. The treatment shall meet these requirements:

(1) Be rehabilitative and restorative in nature;

(2) be provided following physical debilitation due to acute physical trauma or physical illness; and

(3) be prescribed by the attending physician.

(xxx) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of business. These costs shall be considered intangible assets because they represent expenditures for rights and privileges that



have value to the enterprise. Because the services inherent in organization extend over more than one accounting period, the costs shall be amortized over a period of not less than 60 months from the date of incorporation for the purposes of computing reimbursable costs under a cost-related reimbursement system.

(yyy) "Orthotics and prosthetics" means devices that meet these requirements:

- (1) Are reasonable and necessary for treatment of an illness or injury;
- (2) are prescribed by a physician;
- (3) are necessary to replace or improve functioning of a body part; and
- (4) are provided by a trained orthotist or prosthetist.

(zzz) "Other developmental disability" means a condition or illness that meets the following criteria:

- (1) Is manifested before age 22;
- (2) may reasonably be expected to continue indefinitely;
- (3) results in substantial limitations in any three or more of the following areas of life functioning:
  - (A) Self-care;
  - (B) understanding and the use of language;
  - (C) learning and adapting;
  - (D) mobility;
  - (E) self-direction in setting goals and undertaking activities to accomplish those goals;
  - (F) living independently; or
  - (G) economic self-sufficiency; and
- (4) reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of extended or lifelong duration and are individually planned and coordinated.

(aaaa) "Out-of-state provider" means any provider that is physically located more than 50 miles beyond the border of Kansas, except those providing services to children who are wards of the secretary. The following shall be considered out-of-state providers if they are physically located beyond the border of Kansas:

- (1) Nursing facilities;
- (2) intermediate care facilities;
- (3) community mental health centers;
- (4) partial hospitalization service providers; and
- (5) alcohol and drug program providers.

(bbbb) "Outpatient treatment" means services provided by the outpatient department of a hos-

pital, a facility that is not under the administration of a hospital, or a physician's office.

(cccc) "Over-the-counter" means any item available for purchase without a prescription order.

(dddd) "Owner" means a sole proprietor, member of a partnership, or a corporate stockholder with five percent or more interest in the corporation. The term "owner" shall not include minor stockholders in publicly held corporations.

(eeee) "Partial hospitalization program" means an ambulatory treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and daily living skills treatment modalities, based upon a treatment plan.

(ffff) "Participating provider" means any individual or entity that presently has an agreement with the agency to furnish medicaid services.

(gggg) "Pharmacy" means the premises, laboratory, area, or other place meeting these conditions:

(1) Where drugs are offered for sale, the profession of pharmacy is practiced, and prescriptions are compounded and dispensed;

(2) that has displayed upon it or within it the words "pharmacist," "pharmaceutical chemist," "pharmacy," "apothecary," "drugstore," "drug-gist," "drugs," "drug sundries," or any combinations of these words or words of similar import; and

(3) where the characteristic symbols of pharmacy or the characteristic prescription sign "Rx" are exhibited. The term "premises" as used in this subsection refers only to the portion of any building or structure leased, used, or controlled by the registrant in the conduct of the business registered by the board at the address for which the registration was issued.

(hhhh) "Pharmacist" means any person duly licensed or registered to practice pharmacy by the state board of pharmacy or by the regulatory authority of the state in which the person is engaged in the practice of pharmacy.

(iiii) "Physical therapy" means treatment that meets these criteria:

(1) Is provided by a physical therapist registered in the jurisdiction where the service is provided or by the Kansas board of healing arts;

(2) is rehabilitative and restorative in nature;

(3) is provided following physical debilitation due to acute physical trauma or physical illness; and

(4) is prescribed by the attending physician.

(jjjj) "Physician extender" means a person registered as a physician's assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided, and who is working under supervision as required by law or administrative regulation.

(kkkk) "Practitioner" means any person licensed to practice medicine and surgery, dentistry, or podiatry, or any other person licensed, registered, or otherwise authorized by law to administer, prescribe, and use prescription-only drugs in the course of professional practice.

(llll) "Prescribed" means the issuance of a prescription order by a practitioner.

(mmmm) "Prescription" means either of the following:

- (1) A prescription order; or
- (2) a prescription medication.

(nnnn) "Prescription medication" means any drug, supply, or device that is dispensed according to a prescription order. If indicated by the context, the term "prescription medication" may include the label and container of the drug, supply, or device.

(oooo) "Prescription-only" means an item available for purchase only with a prescription order.

(pppp) "Primary care case management" or "PCCM" means a type of managed care whereby a beneficiary is assigned a primary care case manager who manages costs and quality of services by providing case assessment, primary services, treatment planning, referral, and follow-up in order to ensure comprehensive and continuous service and coordinated reimbursement.

(qqqq) "Primary diagnosis" means the most significant diagnosis related to the services rendered.

(rrrr) "Prior authorization" means the approval of a request to provide a specific service before the provision of the service.

(ssss) "Program" means the Kansas medicaid/medikan program.

(tttt) "Proper interest" means interest incurred at a rate not in excess of what a prudent borrower would have had to pay under market conditions existing at the time the loan was made.

(uuuu) "Prospective, reasonable, cost-related reimbursement" means present and future reimbursement, based on analysis and consideration of historical costs related to patient care.

(vvvv) "Qualified medicare beneficiary" or

"QMB" means an individual meeting these requirements:

(1) Who is entitled to medicare hospital insurance benefits under part A of medicare;

(2) whose income does not exceed a specified percent of the official poverty level as defined by the United States executive office of management and budget; and

(3) whose resources do not exceed twice the supplemental security income resource limit.

(www) "Readmission" means the subsequent admission of a consumer as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another DRG hospital.

(xxxx) "Related parties" means two or more parties to a transaction, one of which has the ability to influence the other or others in a way in which each party to the transaction might fail to pursue its own separate interests fully. Related parties shall include those related by family, business, or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations. Transactions or agreements that are illusory or a sham shall not be recognized.

(yyyy) "Related to the community mental health center" means that the agency or facility furnishing services to the community mental health center meets any of these requirements:

(1) Is directly associated or affiliated with the community mental health center by formal agreement;

(2) governs the community mental health center; or

(3) is governed by the community mental health center.

(zzzz) "Residence for the payment of hospice services" means a hospice consumer's home or the nursing facility in which a hospice consumer is residing.

(aaaaa) "Revocation statement" means the statement signed by the consumer that revokes the election of hospice service.

(bbbbb) "Sampling" means the review process of obtaining a stratified random sample of a subset of cases from the universe of claims submitted by a specific provider. The sample shall be used to project the review results across the entire universe of claims for that provider to determine an overpayment.

(ccccc) "Speech therapy" means treatment provided by a speech pathologist who has a cer-

tificate of clinical competence from the American speech and hearing association. The treatment shall meet these requirements:

- (1) Be rehabilitative and restorative in nature;
- (2) be provided following physical debilitation due to acute physical trauma or physical illness; and

- (3) be prescribed by the attending physician.

(ddddd) "Standard diagnosis-related group amount" or "standard DRG amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis-related group weight.

(eeee) "State-operated hospital" means an establishment operated by the state of Kansas that provides diagnosis and treatment for nonrelated patients and includes the following:

- (1) An organized medical staff of physicians;
- (2) permanent facilities that include inpatient beds; and

- (3) medical services that include physician services and continuous registered professional nursing services for 24 hours each day.

(ffff) "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

(ggggg) "Swing bed" means a hospital bed that can be used interchangeably as a hospital, skilled nursing facility, or intermediate care facility bed, with reimbursement based on the specific type of care provided.

(hhhhh) "Targeted case management services" means those services that assist medicaid consumers in gaining access to medically necessary care. The services shall be provided by a case manager with credentials specified by the secretary.

(iiii) "Terminally ill" means that an individual has a life expectancy of six months or less as determined by a physician.

(jjjjj) "Timely filing" means the receipt by the agency or its fiscal agent of a claim for payment filed by a provider for services provided to a medicaid program consumer not later than 12 months after the date the claimed services were provided.

(kkkkk) "Transfer" means the movement of an individual receiving general hospital inpatient services from one hospital to another hospital for additional, related inpatient care after admission to the previous hospital or hospitals.

(lllll) "Transferring hospital" means the hospital that transfers a consumer to another hospital. There may be more than one transferring hospital for the same consumer until discharge.

(mmmmm) "Uncollectable overpayment to an out-of-business provider" means either of the following:

- (1) Any amount that is due from a provider of medical services who has ceased all practice or operations for any medical services as an individual, a partnership, or a corporate identity, and who has no assets capable of being applied to any extent toward a medicaid overpayment; or

- (2) any amount due that is less than its collection and processing costs.

(nnnnn) "Urgent" means that a situation requires medical treatment within two days of onset, but not through the emergency room. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended Jan. 2, 1990; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended, T-30-3-1-91, March 1, 1991; amended July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended May 1, 1992; amended July 31, 1992; amended May 3, 1993; amended Oct. 1, 1993; amended July 1, 1994; amended April 1, 1995; amended Sept. 1, 1995; amended March 1, 1996; amended July 1, 1996; amended July 1, 1997; amended July 6, 2001.)

**30-5-59. Provider participation requirements.** The following shall be prerequisites for participation in and payment from the medicaid/medikan program. Any provider of services to foster care consumers, adoption support consumers, Kan Be Healthy consumers, or other consumers who have special needs may be excluded from these prerequisites if the secretary determines that a medically necessary item of durable medical equipment or a medically necessary service can be cost-efficiently obtained only from a provider not otherwise eligible to be enrolled within the current program guidelines. (a) Enrollment. Each participating provider shall perform the following:

- (1) Submit an application for participation in the medicaid/medikan program on forms prescribed by the secretary of the Kansas department of social and rehabilitation services;

- (2) obtain and maintain professional or depart-

ment-specified credentials determined by the secretary in the jurisdiction where the service is provided and for the time period when the service is provided and, if applicable, be certified, licensed, or registered by the appropriate professional credentialing authority;

(3) notify the Kansas department of social and rehabilitation services if any of the original information provided on the application changes during the term of participation in the medicaid/medikan program;

(4) after completing the necessary application forms and receiving notice of approval to participate from the department, enter into and keep a provider agreement with the Kansas department of social and rehabilitation services;

(5) notify the Kansas department of social and rehabilitation services when a change of provider ownership occurs, submit new ownership information on forms for application for participation in the medicaid/medikan program, and receive approval from the department for participation as a new provider before reimbursement for services rendered to medicaid/medikan program consumers is made;

(6) locate a consumer service representative who is available 24 hours per day and a business in Kansas or a border city that is accessible, in accordance with the applicable Americans with disabilities act guidelines, to the general public between the hours of 9:00 a.m. and 5:00 p.m. at a minimum, excluding weekends and state and federal holidays, if applying to be a durable medical equipment or medical supply provider. Any pharmacy located in Kansas or a border city that has a medical provider number may enroll as a durable medical equipment provider even if no storefront is present; and

(7) be located in Kansas or a border city if applying to be a pharmacy, unless the pharmacy is providing services to children in the custody of the secretary of the Kansas department of social and rehabilitation services or to program consumers in emergency situations. The only exceptions to this requirement shall be the following:

(A) A pharmacy that is an approved contractor with the Kansas department of health and environment as a supplier of intravenous blood fraction products. This exception shall apply only to reimbursement for the intravenous blood fraction products; and

(B) a mail order pharmacy that serves medicaid

consumers with a primary payor other than medicaid.

(b) Denial of application. If an application for participation in the medicaid/medikan program is denied, the applicant shall be notified in writing by the department.

(c) Continuing participation. Each participating provider shall perform the following:

(1) Comply with applicable state and federal laws, regulations, or other program requirements;

(2) comply with the terms of the provider agreement;

(3) submit accurate claims or cost reports;

(4) submit claims only for covered services provided to consumers;

(5) engage in ethical and professional conduct;

(6) provide goods, services, or supplies that meet professionally recognized standards of quality;

(7) submit a new application for participation in the medicaid/medikan program if a claim has been submitted for payment and if at least 18 months have elapsed since a previous claim for payment was submitted; and

(8) refund any overpayment to the program within a period of time specified by the secretary or lose eligibility to participate.

(d) Recordkeeping. Each participating provider shall perform the following:

(1) Maintain and furnish within the time frame specified in a request any information for five years from the date of service that the Kansas department of social and rehabilitation services, its designee, or any other governmental agency acting in its official capacity may request to ensure proper payment by the medicaid/medikan program, to substantiate claims for medicaid/medikan program payments, and to complete determinations of medicaid/medikan program overpayments. This information shall include the following:

(A) Fiscal, medical, and other recordkeeping systems;

(B) matters of the provider's ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(C) documentation of asset acquisition, lease, sale, or other action;

(D) franchise or management arrangements;

(E) matters pertaining to costs of operation;

(F) amounts of income received, by source and purpose; and



(G) a statement of changes in financial position;

(2) use standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the provider's field;

(3) permit the Kansas department of social and rehabilitation services, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the medicaid/medikan program; and

(4) agree to repay overpayment determinations resulting from the use of sampling techniques.

(e) Payment. Each participating provider shall meet the following conditions:

(1) Accept as payment in full, subject to audit when applicable, the amount paid by the medicaid/medikan program for covered services;

(2) not assign medicaid/medikan program claims or grant a power of attorney over or otherwise transfer right to payment for these claims except as set forth in 42 CFR 447.10, revised July 24, 1996, which is adopted by reference;

(3) not charge medicaid/medikan program consumers for services denied for payment by the medicaid/medikan program because the provider has failed to meet a program requirement including prior authorization;

(4) not charge any medicaid/medikan program consumer for noncovered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for noncovered services;

(5) not charge medicaid/medikan program consumers for services covered by the program, with the exception of claims liable to spenddown or copayment;

(6) submit claims for payment on claim forms approved and prescribed by the secretary; and

(7) be subject to the payment limitations specified in K.A.R. 30-5-70.

(f) Provider participation in the medicaid/medikan program may be disallowed for any of the reasons set forth in K.A.R. 30-5-60. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended May 1, 1992; amended May 3, 1993; amended Dec. 30, 1994;

amended April 1, 1995; amended Oct. 1, 2000; amended Jan. 1, 2004; amended Dec. 10, 2004.)

**30-5-60. Provider termination/suspension.** (a) Any provider's participation in the medicaid/medikan program may be terminated for one or more of the following reasons:

(1) Voluntary withdrawal of the provider from participation in the program;

(2) non-compliance with applicable state laws, administrative regulations, or program issuances concerning medical providers;

(3) non-compliance with the terms of a provider agreement;

(4) non-compliance with the terms and certification set forth on claims submitted to the agency for reimbursement;

(5) assignment, granting a power of attorney over, or otherwise transferring right to payment of program claims except as set forth in 42 U.S.C. 1396a (32), revised July 18, 1984, which is adopted by reference;

(6) pattern of submitting inaccurate billings or cost reports;

(7) pattern of submitting billings for services not covered under the program;

(8) pattern of unnecessary utilization;

(9) unethical or unprofessional conduct;

(10) suspension or termination of license, registration, or certification;

(11) provision of goods, services, or supplies harmful to individuals or of an inferior quality;

(12) civil or criminal fraud against medicare, the Kansas medicaid/medikan or social service programs, or any other state's medicaid or social service programs;

(13) suspension or exclusion by the secretary of health and human services from the title XVIII or title XIX programs;

(14) direct or indirect ownership or controlling interest of five percent or more in a provider institution, organization or agency by a person who has been found guilty of civil or criminal fraud against the medicare program or the Kansas medicaid/medikan or social service programs or any other state's medicaid or social service programs;

(15) employment or appointment by a provider of a person in a managerial capacity or as an agent if the person has been found guilty of civil or criminal fraud against the medicare program or the Kansas medicaid/medikan or social service programs or any other state's medicaid or social service programs;

- (16) insolvency; or
- (17) other good cause.

(b) Termination, unless based upon civil or criminal fraud against the program, suspension or exclusion by the secretary of health and human services, shall remain in effect until the agency determines that the reason for the termination has been removed and that there is a reasonable assurance that it shall not recur. Terminations based upon civil or criminal fraud shall remain in effect for such time period as deemed appropriate by the agency. Termination based upon suspension or exclusion by the secretary of health and human services (HHS) shall remain in effect no less than the time period specified in HHS' notice of suspension.

(c) Prior to the termination of a provider from the program, the provider shall be sent a written notification by the agency of the proposed termination and the reasons. The notice shall state whether payment liability to the provider has been suspended pending further proceedings. The notice shall further advise the provider that an appearance before the section may be permitted at a specified time, not less than five days nor more than 15 days from the date the notice is mailed to or served upon the provider. At the appearance the provider may present any relevant evidence and have an opportunity to be heard on the question of continuing eligibility in the program. All evidence presented, including that of the provider, shall be considered by the agency. If the decision is to terminate, a written order of termination shall be issued, setting forth the effective date of the termination and the basic underlying facts supporting the order.

(d) Any provider found not to be in compliance with one or more requirements set forth in K.A.R. 30-5-59 may be subject to suspension of payment or other remedies in lieu of termination. The effective date of this regulation shall be May 3, 1993. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective May 1, 1981; amended May 1, 1986; amended July 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended May 3, 1993.)

**30-5-61.** (Authorized by K.S.A. 1979 Supp. 39-708c; effective May 1, 1981; amended, T-84-11, July 1, 1983; revoked May 1, 1984.)

#### **30-5-61a. Withholding of payments to**

**medical providers.** (a) Payments otherwise authorized to be made to medical providers shall be withheld, in full or in part, by the agency when:

(1) The agency has determined that the provider to whom payments are to be made has been overpaid;

(2) the agency has reliable evidence, although additional evidence may be needed for a determination, that an overpayment exists or that the payment to be made may not be correct; or

(3) the agency has been instructed by the department of health and human services (HHS) to withhold all or part of the federal share from payment to a medical provider.

(b) A withholding action shall become effective immediately unless a later date is set forth in the letter of notification. The agency, no later than the effective date of the withholding action, shall send written notification of the withholding and the reasons therefor to the affected medical provider.

(c) A withholding action shall remain in effect until:

(1) The overpayment is recouped from the amount withheld or is otherwise recovered;

(2) the agency enters into an agreement with the provider for recovery of the over payment;

(3) the agency, on the basis of subsequently acquired evidence or otherwise, determines that there is no overpayment; or

(4) the agency is otherwise notified by HHS if the withholding action is pursuant to federal instructions. No payment for the withheld federal share shall be made to any medical provider unless the agency receives notification from HHS to do otherwise.

(d) Whenever payments to a medical provider are withheld pursuant to paragraph (a)(2), the agency shall take timely action to obtain any additional evidence the agency may need to make a determination as to whether an overpayment exists or whether payments should be made. The agency shall make all reasonable efforts to expedite the determination. As soon as the determination has been made, the provider shall be informed and, when appropriate, the withholding action shall be rescinded or adjusted to take into account the determination. If not rescinded, the withholding action shall remain in effect as specified in paragraph (c) above. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1984.)

#### **30-5-61b. Suspension of payment liabil-**

**ity to medical providers.** (a) Suspension of payment liability because of determination by the secretary of health and human services. The agency shall suspend payment liability for services provided by any medical provider during any time period in which payments may not be made to the provider under titles XVIII or XIX of the social security act because of a determination by the secretary of health and human services pursuant to 42 U.S.C.A. 1395y(d)(1) and (e)(1), clause (C)(ii), (D), (E) or (F) of 42 U.S.C.A. 1395cc (b)(2). The suspension shall be effective upon receipt of the notification of the determination by the department of health and human services (HHS) and shall remain in effect until the agency is otherwise notified by HHS. The agency, no later than the effective date of the suspension, shall send written notification of the suspension and the reasons therefore to the affected medical provider. No payment shall be made to any medical provider for services provided by the medical provider during the time period of suspension unless the agency receives notification from HHS to do otherwise.

(b) Suspension of payment liability upon notification of proposed termination.

(1) Payment liability may be suspended by the agency upon notification to a provider of a proposed termination if the provider may no longer legally provide services or for other good cause. No payment shall be made to a provider for services rendered after the provider receives notification of the suspension.

(2) If payment liability is suspended to an adult care home, payment liability for those program recipients who are living in the home at the time of the suspension may be continued, for a period not to exceed 30 days, to facilitate the orderly transfer of the recipients to another facility or to alternate care. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1984.)

**30-5-62. Reinstatement of a provider previously terminated from the medicaid/medikan program.** A request for reinstatement by a provider terminated from participation in the medicaid/medikan program shall not be considered for a period of 60 days following the effective date of the order of termination. As a prerequisite for reinstatement in the program one or more of the following conditions may be imposed by the agency: (a) Implementation and documentation of

corrective action taken by the provider to comply with program policies and to reasonably insure that the reason for the termination shall not recur;

- (b) probationary period not to exceed one year;
- (c) attendance at provider education sessions;
- (d) prior authorization of services;
- (e) peer supervision; and
- (f) other conditions as the specific situation may warrant. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

**30-5-63. Medical necessity.** Except as specifically set forth in program policy, the agency shall not reimburse a provider for the provision of a covered service to a program recipient unless the provision of the service was medically necessary. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

**30-5-64.** (Authorized by K.S.A. 39-708c(b) and K.S.A. 2004 Supp. 39-7,120; implementing K.S.A. 2004 Supp. 39-7,120 and 39-7,121a; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended May 1, 1992; amended July 1, 1994; amended March 1, 1995; amended March 1, 1996; amended July 1, 1996; amended July 1, 1997; amended Jan. 1, 1999; amended April 1, 2000; amended Oct. 1, 2000; amended Oct. 1, 2001; amended Dec. 6, 2002; amended Feb. 21, 2003; amended May 9, 2003; amended July 11, 2003; amended Aug. 8, 2003; amended Nov. 14, 2003; amended Dec. 29, 2003; amended May 28, 2004; amended Oct. 29, 2004; amended Jan. 7, 2005; amended April 1, 2005; amended May 27, 2005; revoked Oct. 28, 2005.)

**30-5-65.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended May 1, 1992; amended July 1, 1994; revoked July 13, 2007.)

**30-5-66. Effective date of administrative regulations in relationship to provider cost reporting periods.** The administrative regulations in effect at the beginning of a cost reporting period shall govern the treatment of costs that accrue during said period unless otherwise provided. (Authorized by and implementing

K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.)

**30-5-67. Disallowance of claims for services generated by providers ineligible for participation in the medicaid/medikan program.** The agency shall disallow payment, except for emergency services, if the service set forth on a claim was generated by a provider ineligible to participate in the medicaid/medikan program. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

**30-5-68. Consultants to the medicaid/medikan program.** Consultants to the medicaid/medikan program may be reimbursed if under contract with the Kansas department of social and rehabilitation services. The payment rate for consultants shall be a mutually negotiated amount. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1986; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990.)

**30-5-69. Volume purchase and negotiated contracts for medical services.** The agency may procure medical services from a single or multiple source through competitive bidding or negotiated fee. The agreed upon reimbursement shall supersede the usual reimbursement methodology for the service. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982.)

**30-5-70. Payment of medical expenses for eligible recipients.** (a) Payment for covered services shall be made only to those providers participating in the program pursuant to K.A.R. 30-5-59. The only exceptions shall be pursuant to K.A.R. 30-5-65.

(b) Each program recipient shall be eligible for the payment of specific medical expenses as follows:

(1) Payment of Medicare (title XVIII) premiums and deductibles and co-insurance amounts for services covered in the medicaid program. Recipients who are ineligible for program coverage because they have a spenddown shall be eligible for the payment of the Medicare (title XVIII) premium expense. For cash recipients, including SSI recipients, who are age 65 or older, payment of

the Medicare (title XVIII) premium shall begin with the month of approval for medicaid, excluding any months of prior eligibility. For recipients under age 65 who are eligible for Medicare after receiving retirement and survivor's disability insurance for 24 consecutive months, payment of the Medicare (title XVIII) premium shall begin with the 25th month. For all other recipients, payment of the Medicare (title XVIII) premium shall begin with the second month following the month of approval for medicaid, excluding any months of prior eligibility;

(2) payment of premiums of health maintenance organizations that are approved by the agency or premiums of group health plans offered by the recipient's employer if the agency has determined that this plan is cost-effective;

(3) payment of other allowable medical expenses incurred in the current eligibility base period in excess of any co-pay or spenddown requirements;

(4) payment for services rendered to a person who is mandated to receive inpatient treatment for tuberculosis and who is not otherwise eligible for participation in the program. Coverage shall be limited to services related to the treatment for tuberculosis;

(5) payment for services in excess of medicaid/medikan program limitations for foster care and adoption support recipients, when approved by the agency; and

(6) payment for covered medical services provided to an individual participating in the KanWork program. A monthly cost-sharing amount for medical services shall be paid by each individual participating in the KanWork program when required.

(c) The scope of services provided to recipients and the payment for those services shall be as set forth in articles 5 and 10 of this chapter, subject to the following limitations.

(1) Payment for a particular medical expense shall be denied if it is determined that any one of these conditions is met:

(A) The recipient failed to utilize medical care available through other community resources, including public institutions, veterans administration benefits, and those laboratory services that are available at no charge through the state department of health and environment.

(B) A third party liability for the medical expense has been established and is available.



(C) The recipient fails to make a good faith effort to establish a third party liability for the medical expense or fails to cooperate with the agency in establishing the liability. Payment of a medical expense may be delayed pending the outcome of a determination concerning third party liability.

(D) The expense is not covered or is only partially covered by an insurance policy because of an insurance program limitation or exclusion.

(E) The recipient failed to notify the provider of services of the recipient's eligibility for the program.

(F) The service is cosmetic, pioneering, or experimental, or is a result of complications related to these procedures.

(G) The service is related to transplant procedures that are not covered by the medicaid/medikan program.

(H) The service was provided by a provider not designated as a lock-in provider for any recipient who is locked into designated providers due to abuse, unless the provider has a written referral from a designated provider or unless the service was an emergency service.

(I) The service was provided by a provider not designated as the primary care case manager for any recipient who is enrolled in the primary care case manager program, unless the provider has a written referral from the designated provider or unless the service was an emergency service.

(J) The service was covered in a health maintenance organization plan for any recipient enrolled in a health maintenance organization.

(K) The service was provided by an unlicensed, unregistered, or noncertified provider when licensure, registration, or certification is a requirement to participate in the medicaid/medikan program.

(L) The service exceeds the limitations defined by the program policies.

(2) Payment for out-of-state services shall be limited to the following:

(A) Payment on behalf of recipients if medical services are normally provided by medical vendors that are located in the bordering state and within 50 miles of the state border, except for community mental health center services, alcohol and drug abuse services, or partial hospitalization services;

(B) emergency services rendered outside the state;

(C) nonemergency services for which prior approval by the agency has been given. Authorization

from the agency shall be obtained before making arrangements for the individual to obtain the out-of-state services;

(D) services provided by independent laboratories; and

(E) medical services provided to foster care recipients and medical services in excess of the limitations of the state of residence, when approved by the Kansas department of social and rehabilitation services and within the scope of the adoption agreement for those for whom Kansas has initiated adoption support agreements.

(3) The scope of services for adult non-medicare (non-title XIX) program recipients shall be limited as set forth in K.A.R. 30-5-150 through 30-5-172.

(d) Payment for medical services shall be made, at the discretion of the secretary, when it has been determined that an agency administrative error has been made.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c and K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-44, Jan. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended May 3, 1993; amended July 19, 1996; amended Oct. 1, 1998.)

### **30-5-71. Copayment requirements.**

(a) Except as set forth in subsection (b) of this regulation, program recipients shall be obligated to the provider for the following copayment charges.

(1) The copayment for inpatient general hospital and freestanding psychiatric facility services shall be \$48.00 per admission.

(2) The copayment for outpatient general hospital services shall be \$1.00 per non-emergency visit in place of a doctor's office visit.

(3) The copayment for other medical services subject to copayment shall be based upon the following ranges:

average medicaid/medikan payment for services	maximum copayment chargeable to recipient
\$10.00 or less	\$ .50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

(4) The copayment for other medical services subject to copayment shall be a standard amount based upon the average medicaid payment for the services, calculated on an annual basis. The average medicaid payment shall be calculated by dividing the cost of the services in aggregate by the total number of claims paid in the previous fiscal year. Any change in copayment shall be published in the Kansas Register on or before December fifteenth to be effective January first of each year.

(5) Other medical services subject to copayment shall include the following:

(A) Ambulatory surgical center services, for each date of service;

(B) audiological services, excluding batteries, for each date of service;

(C) community mental health center services, for each individual psychotherapy visit;

(D) durable medical equipment, prosthetics, and orthotics, for each claim, excluding the rental of durable medical equipment;

(E) home health services, for each skilled nursing visit, excluding the rental of durable medical equipment;

(F) non-emergency ambulance services, for each date of service;

(G) optometric or ophthalmologist services, for each date of service;

(H) outpatient general hospital surgery, for each date of service;

(I) prescribed drugs, for each new or refilled prescription;

(J) physician or physician extender services, for each office visit;

(K) podiatric services, for each office visit;

(L) psychological services, for each office visit;

(M) dietician services, for each date of service;

(N) dental services, for each date of service;

(O) federally qualified health center services, for each encounter; and

(P) rural health clinic services, for each encounter.

(b) The provisions of subsection (a) shall not apply to services provided as follows:

(1) To residents in nursing facilities, including swing beds, intermediate care facilities for the

mentally retarded, nursing facilities for mental health, and to recipients participating in the home- and community-based services programs;

(2) to inpatients in a state psychiatric hospital who meet both of the following conditions:

(A) Have reached the age of 18 but are not yet 22 years of age; or

(B) are at least 65 years of age;

(3) to recipients under age 18;

(4) to recipients in the custody of the juvenile justice authority or secretary of social and rehabilitation services who are at least 18 years old but under age 21 and who are in out-of-home placements;

(5) to recipients enrolled in a medicaid-funded health maintenance organization;

(6) for family planning purposes;

(7) for medical services relating to an injury incurred on the job during a community work experience project;

(8) for services related to pregnancy; and

(9) for emergency services. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended, T-83-38, Nov. 23, 1982; amended May 1, 1983; amended, T-84-36, Jan. 1, 1984; amended May 1, 1984; amended May 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended Dec. 31, 1992; amended Sept. 27, 1993; amended Dec. 30, 1994; amended, T-30-6-28-95, July 1, 1995; amended Sept. 1, 1995; amended July 1, 1997; amended Sept. 3, 2004.)

**30-5-72. Medical contracts; funding.** All medical contracts shall be subject to federal and state funding conditioned by appropriations made by congress and the state legislature. (Authorized by and implementing K.S.A. 1980 Supp. 39-708; effective May 1, 1981.)

**30-5-73. Requirements for facilities to participate.** (a) Medical services provided in community mental health centers, free-standing psychiatric facilities, state-operated hospitals, and general hospitals to be reimbursed by the medicaid/medikan program shall be under the effective control of a physician as determined by the agency.

(b) Community mental health centers, free-standing psychiatric facilities, state-operated hospitals, and general hospitals providing medical

services reimbursable by the medicaid/medikan program shall have utilization review programs approved by medicare or the agency. Utilization review programs and their implementation shall be subject to review by the secretary.

(c) Facilities offering medical services shall be licensed or certified by an appropriate Kansas state licensing or certification authority in order to be eligible for reimbursement by the medicaid/medikan program. The effective date of this regulation shall be October 1, 1993. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Oct. 1, 1993.)

**30-5-74.** (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981; revoked May 1, 1986.)

**30-5-75. Scope of services for eligible aliens.** The scope of services shall be limited to emergency medical services for otherwise eligible aliens pursuant to K.A.R. 30-6-54 who do not qualify under the citizenship and alienage requirements. (Authorized by and implementing K.S.A. 39-708c; effective, T-88-14, July 1, 1987; effective May 1, 1988.)

**30-5-76. Scope of coverage and reimbursement for services for qualified medicare beneficiaries.** The scope of coverage for QMBs shall be the reimbursement of medicare premiums and coinsurance under part A and part B of medicare, for covered and noncovered medicaid/medikan services. The reimbursement rates shall be based upon the methodologies specified in this article, and the combination of medicare and medicaid payments shall not exceed payments at the current medicaid/medikan reimbursement rates. If the medicare payment exceeds the payment at the current medicaid/medikan reimbursement rate, no further payment shall be made. Reimbursement rates for services not otherwise covered by medicaid/medikan shall not exceed 80 percent of the current medicare allowable reimbursement rates or shall be determined by the secretary. This regulation shall be effective on and after January 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989; amended Jan. 1, 2002.)

**30-5-77. Scope of home- and community-based services for technology-assisted children.** The scope of home- and community-

based services for technology-assisted children shall consist of those services provided under the authority of a federally approved waiver. Home- and community-based services shall be provided in accordance with a written plan of care by a home health agency and approved by the Kansas department of social and rehabilitation services. (a) Services may include one or more of the following:

(1) An average of 10 hours per month of case management services;

(2) a maximum of seven days or 168 hours per calendar year of respite care provided in the home; and

(3) medical equipment and supplies not otherwise covered under the medicaid program and approved in the plan of care.

(b) Reimbursement for services for technology-assisted children shall be based upon reasonable fees as related to customary charges, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. The effective date of this regulation shall be July 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-3-1-91, March 1, 1991; effective July 1, 1991.)

**30-5-78.** (Authorized by and implementing K.S.A. 39-708c; effective, T-30-8-9-91, Aug. 30, 1991; effective Oct. 28, 1991; amended Oct. 1, 1998; amended Jan. 1, 2004; revoked July 18, 2008.)

**30-5-79. Scope of and reimbursement for home- and community-based services for persons with mental retardation or other developmental disabilities.** The scope of home- and community-based services for persons with mental retardation or other developmental disabilities shall consist of those services provided under the authority of the applicable federally-approved waiver to the Kansas medicaid state plan. (a) Prior to the development of any plan to provide services, the need for services shall be determined by an individualized assessment of the prospective recipient by a provider of community-based screening services.

(b) Home- and community-based services shall be provided in accordance with an individualized, written plan of care approved in writing by the Kansas department of social and rehabilitation services. Each annual review and amendment of

this plan shall be approved in the same fashion. This plan shall:

(1) Be based on needs identified during the screening assessment;

(2) specify each service to be provided and why each service was selected, or how each service will address any specific need identified by the assessment;

(3) specify the frequency, and within what limits, each service shall be provided;

(4) specify what other support services are required and the plan for obtaining them;

(5) be prepared in consultation with the recipient or the recipient's guardian, if one has been appointed;

(6) be approved in writing by the recipient or the recipient's guardian, as appropriate; and

(7) be reviewed at least annually and updated as necessary.

(c) Reimbursement for home- and community-based services for persons with mental retardation or other developmental disabilities shall be based upon reasonable fees as related to customary charges, except that no fee shall be paid in excess of the range maximum. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 39-708c; effective, T-30-8-9-91, Aug. 30, 1991; effective Oct. 28, 1991.)

**30-5-80.** This regulation shall be revoked on and after July 1, 1997. (Authorized by and implementing K.S.A. 1996 Supp. 39-708c; effective July 31, 1992; amended Dec. 29, 1995; revoked July 1, 1997.)

**30-5-81. Scope of hospital services.** (a) Each hospital shall be medicare-certified and shall annually update medicaid enrollment information.

(b) Outpatient services shall be covered with the following limitations.

(1) Services shall be ordered by an attending physician who is not serving as an emergency room physician, except for those services related to emergency situations. Orders shall be related specifically to the present diagnosis of the recipient.

(2) A prosthetic device shall replace all or part of an internal body organ or shall replace one of these devices.

(3) (A) Rehabilitative therapies shall be restorative in nature.

(B) Rehabilitative therapies shall be provided

following physical debilitation due to acute physical trauma or physical illness.

(C) Rehabilitative therapies shall be prescribed by the attending physician.

(4) Services provided in the emergency department shall be emergency services.

(5) Elective surgery shall not be covered, except for sterilization operations or operations for Kan Be Healthy program participants.

(6) Ambulance services shall not be covered.

(7) Nonemergency visits in place of physician office visits shall be considered physician office visits and shall be counted against the physician office visit limitation.

(8) Outpatient hospital assessment of the need for emergency service shall not be covered.

(c) Inpatient services shall be covered, subject to the following limitations.

(1) Services shall be ordered by a physician and shall be related specifically to the present diagnosis of the recipient.

(2) Transplant surgery shall be limited to the following:

(A) Liver transplants, which shall be performed only at a hospital designated by the secretary unless the medical staff of that hospital recommends another location; and

(B) corneal, kidney, and bone marrow transplants and related services.

(3) A recipient of general hospital inpatient services shall not be billed for those days determined to be medically unnecessary. If a recipient refuses to leave a hospital after the recipient's physician writes a discharge order, the days after discharge that the recipient remains in the hospital may be billed to the recipient.

(4) A provider shall not be reimbursed for services provided on the day of discharge.

(5) Long-term care services in swing beds shall be provided pursuant to 42 CFR part 482, subpart E, revised October 1, 1999, which is adopted by reference.

(6) A provider shall not be reimbursed on an inpatient basis for therapeutic and diagnostic surgical services, and related services that can be performed on an outpatient basis. A provider shall not be reimbursed on an inpatient basis unless the service provider documents medical necessity.

(7) Inpatient services shall be subject to utilization review, which shall determine the following:

(A) Whether services are medically necessary;



(B) whether services are furnished at the appropriate level of care;

(C) whether services are of a quality that meets professionally recognized standards;

(D) whether a discharge is premature;

(E) whether a transfer is necessary; and

(F) whether the procedure coding and the diagnosis coding on a claim are correct.

(8) Psychotherapy, directed by a psychiatrist or approved hospital staff under the direction of a psychiatrist, shall be provided to each psychiatric patient on a daily basis.

(9) Substance abuse treatment services shall be limited to three treatment admissions per recipient's lifetime, regardless of the type of provider.

(10) Inpatient acute care related to substance abuse treatment services shall be limited to those patients who are in need of acute detoxification.

(11) Elective surgery shall not be covered, except for sterilization operations or operations for Kan Be Healthy program participants. (Authorized by and implementing K.S.A. 1999 Supp. 39-708c; effective May 1, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended May 1, 1983; amended, T-84-7, March 29, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended, T-89-24, May 27, 1988; amended Sept. 26, 1988; amended, T-30-10-28-88, Oct. 28, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-7-29-89, July 29, 1989; amended Nov. 24, 1989; amended Aug. 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended July 1, 1996; amended Oct. 6, 2000.)

**30-5-81a. Participation in the diagnosis related group reimbursement system.** As a prerequisite for participation in the medicaid/medikan program, a general hospital shall participate in the Kansas department of social and rehabilitation services' diagnosis related group reimbursement system. The effective date of this regulation shall be January 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective, E-82-6, May 1, 1981; effective May 1, 1982; amended, T-84-7, May 1, 1983; amended May 1, 1984; amended July 1, 1989.)

**30-5-81b. The basis of reimbursement for hospital services.** (a) Payment for hospital

services provided to program participants shall be made to those hospitals filing cost reports with the Kansas department of social and rehabilitation services. Cost reports shall be due 30 days after the due date of the medicare cost report to the medicare fiscal intermediary.

(b) General hospitals; inpatient services. For covered services rendered to program recipients, each general hospital shall be reimbursed on the basis of the diagnosis related group reimbursement system pursuant to the provisions of K.A.R. 30-5-81t through 30-5-81v except as set forth below.

(c) General hospitals; outpatient services. For covered services rendered to program recipients, each general hospital shall be reimbursed based on the reimbursement methodology for comparable services rendered by non-hospital providers. For laboratory and radiology services, each general hospital shall be reimbursed its customary charges not to exceed the range maximum set forth in K.A.R. 30-5-85a plus 2%.

(d) General hospitals; long term care in swing bed hospitals. For covered services rendered to program recipients, each general hospital shall be reimbursed pursuant to 42 CFR 447.250 through 447.280, revised October 1, 1988, which are adopted by reference.

(e) State-operated hospitals. Each state-operated hospital shall be reimbursed the lesser of reasonable costs or customary charges for covered inpatient services rendered to program recipients. Each state-operated hospital shall be reimbursed reasonable fees as related to customary charges for covered outpatient services rendered to program recipients, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations.

(f) Hospitals which are determined to be disproportionate share hospitals shall be reimbursed with a disproportionate share payment adjustment as determined in accordance with the Omnibus Budget Reconciliation Act, Public Law 100-203, section 4112, effective July 1, 1988. The effective date of this regulation shall be October 1, 1993. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1981; amended, E-82-6, May 1, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended May 1, 1983; amended, T-84-7, March 29, 1983; amended May 1, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended May 1, 1986; amended, T-87-44, Jan. 1,

1987; amended, T-88-6, March 4, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Aug. 1, 1990; amended Oct. 1, 1993.)

**30-5-81c.** (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981; amended, E-82-6, May 1, 1981; amended May 1, 1982; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81d.** This rule and regulation shall expire on July 1, 1989. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended, E-82-6, May 1, 1981; amended May 1, 1982; amended, T-84-7, March 29, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1987; revoked July 1, 1989.)

**30-5-81e.** (Authorized by and implementing K.S.A. 1979 Supp. 39-708c; effective May 1, 1981; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81f to 30-5-81i.** (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981; amended, E-82-6, May 1, 1981; amended May 1, 1982; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81j.** (Authorized by and implementing K.S.A. 1979 Supp. 39-708c; effective May 1, 1981; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81k and 30-5-81l.** (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981; amended, E-82-6, May 1, 1981; amended May 1, 1982; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81m and 30-5-81n.** (Authorized by and implementing K.S.A. 1979 Supp. 39-708c; effective May 1, 1981; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81o.** (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981; amended, E-82-6, May 1, 1981; amended May 1, 1982; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81p.** (Authorized by and implementing K.S.A. 1979 Supp. 39-708c; effective May 1,

1981; revoked, T-84-7, March 29, 1983; revoked May 1, 1984.)

**30-5-81q.** This rule and regulation shall expire on July 1, 1989. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective, T-84-9, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; revoked July 1, 1989.)

**30-5-81r.** This rule and regulation shall expire on July 1, 1989. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective, T-84-9, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; revoked July 1, 1989.)

**30-5-81s.** This rule and regulation shall expire on July 1, 1989. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective, T-84-9, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; revoked July 1, 1989.)

**30-5-81t. Hospital change of ownership.** (a) Agency notification and provider agreements.

(1) Each hospital shall notify the agency in writing at least 60 days prior to the effective date of the change of ownership. Failure to do so shall result in the forfeiture of rights to payment for covered services provided to recipients by the previous owner or owners in the 60-day period prior to the effective date of the change of ownership. Failure to notify the agency in writing at least 60 days prior to the effective date of the change of ownership shall result in the new owner or owners assuming responsibility for any overpayment made to the previous owner or owners before the effective date of the change of ownership. This shall not release the previous owner of responsibility for such overpayment. This notification requirement may be waived at the discretion of the secretary based upon the showing of good cause by a hospital changing ownership. The new owner or owners shall submit an application to be a provider of services in the program and shall not receive reimbursement for covered services provided to recipients from the effective date of the change of ownership until the date upon which all requirements for participation pursuant to K.A.R. 30-5-59 have been met or until the date upon which an application to be a provider of services in the program is received by the Kansas department of social and rehabilitation services, whichever is later.

(2) At least 60 days before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the agency shall be notified in writing. If the business entity fails to provide 60 days written notice, no reimbursement shall be made. This notification requirement may be waived at the discretion of the secretary based upon the showing of good cause by a hospital changing ownership.

(3) If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of service shall be submitted to the agency by the new owner and affiliated providers.

(4) Transfer of participating provider corporate stock shall not in itself constitute a change of ownership. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of ownership. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of ownership, and an application to be a provider of services shall be submitted to the agency by the new owner and affiliated providers.

(5) Each partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the owner of the facility. Each addition or substitution to a partnership or any change of ownership resulting in a completely new partnership shall require that an application to be a provider of services shall be submitted to the agency by the new owner and affiliated providers.

(6) The change of or a creation of a new lessee, acting as a provider of services, shall constitute a change of ownership. An application to be a provider of services shall be submitted to the agency by the new lessee and affiliated providers. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in ownership.

(b) Certification surveys. Each new owner or owners shall be subject to a certification survey by the department of health and environment and, if certified, the period of certification shall be as established by the department of health and environment.

(c) Cost limitations.

(1) For each asset in existence on July 18, 1984, which is subsequently sold, the valuation of the asset for reimbursement purposes shall be the

lesser of the allowable acquisition cost of the asset to the owner of record on July 18, 1984, or the acquisition cost of the asset to the new owner.

(2) For each asset not in existence on July 18, 1984, the valuation of the asset for reimbursement purposes shall be the lesser of the acquisition cost of the asset to the first owner of record or the acquisition cost of the asset to the new owner.

(3) Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, shall not be allowable. The effective date of this regulation shall be July 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective, T-85-34, Dec. 19, 1984; effective May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended July 1, 1989.)

**30-5-81u. General hospital groups under the diagnosis-related group (DRG) reimbursement system.** (a) Each general hospital participating in the Kansas medicaid/medikan program shall be assigned by the Kansas department of social and rehabilitation services to one of four groups. Each general hospital shall be annually notified by the department in writing of the hospital's group assignment.

(1) Each general hospital assigned to group one shall meet either of the following criteria:

(A) Be located within a metropolitan statistical area within the state of Kansas and have at least 200 general hospital inpatient beds; or

(B) be located within the state of Kansas and within 10 miles of a general hospital meeting the criteria specified in paragraph (a)(1)(A).

(2) Each general hospital assigned to group two shall meet one of the following criteria:

(A) Be located within a metropolitan statistical area in the state of Kansas and have fewer than 200 general hospital inpatient beds;

(B) be located outside of a metropolitan statistical area in the state of Kansas or its border cities and have at least 100 general hospital inpatient beds; or

(C) be located within the state of Kansas and within 10 miles of a general hospital meeting the criteria specified in paragraph (a)(2)(A) or (B).

(3) Each general hospital assigned to group four shall be located outside of the state of Kansas.

(4) A general hospital shall be assigned to group three if it does not meet the criteria specified in paragraphs (a)(1), (a)(2), and (a)(3) above.

(5) A general hospital shall be assigned to

group one if it meets the criteria for assignment to both group one and group two.

(b) General hospital group assignments shall be redetermined annually by the department based upon the criteria in subsection (a). (Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989; amended Dec. 29, 1995; amended, T-30-1-2-03, Jan. 2, 2003; amended April 18, 2003; amended March 18, 2005.)

**30-5-81v. Reimbursement for general hospital inpatient services under the diagnosis related group (DRG) reimbursement system.** (a) The Kansas department of social and rehabilitation services shall reimburse general hospitals for inpatient services provided to recipients covered pursuant to K.A.R. 30-5-81 on the basis of the diagnosis related group (DRG) reimbursement system.

(b) Reimbursement shall be determined as follows:

(1) The standard DRG amount shall constitute reimbursement for each covered general hospital inpatient stay except in circumstances described in subsections (b)(5) and (b)(6) below. An additional payment shall be made for each day outlier or each cost outlier pursuant to subsections (b)(2), (b)(3) and (b)(4) below.

(2) If a covered general hospital inpatient stay is determined to be a cost outlier, the reimbursement for the cost outlier additional payment shall be obtained by multiplying two items: The DRG adjustment percentage and the difference between the estimated cost of the covered inpatient stay and the cost outlier limit.

(3) If a covered general hospital inpatient stay is determined to be a day outlier, the reimbursement for the day outlier additional payment shall be obtained by multiplying three items: The DRG daily rate, the DRG adjustment percentage, and the difference between the actual covered length of inpatient stay and the day outlier limit.

(4) If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the additional payment shall be the greater of the amounts computed in subsections (b)(2) or (b)(3) above.

(5) If a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, the reimbursement to both hospitals shall be determined by a methodology specified by the secretary.

(6) Reimbursement shall not be made for a re-

cipient's readmission to a hospital if the readmission for the same recipient is determined to have resulted from an inappropriate discharge. The effective date of this regulation shall be July 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989.)

**30-5-82. Scope of rural health clinic services.** Rural health clinic services and other ambulatory services shall be covered under the Kansas medical assistance program pursuant to 42 CFR 447.371, effective September 30, 1986, when provided by clinics accepted by the health care financing administration as qualified to furnish rural health clinic services for participation under the medicare program. A clinic may be certified as either an independent or a provider-based rural health clinic. Covered rural health clinic services and other ambulatory services shall include the following: (a) Physician services. These are professional services performed by a physician.

(b) Advanced registered nurse practitioner and physician assistant services. These are professional services furnished by an advanced registered nurse practitioner or a physician assistant under both of the following conditions:

(1) Services are in accordance with medical orders prepared by a physician for the care and treatment of a patient.

(2) A physician is available at least once every two weeks to supervise the delivery of services and to perform services that are not in the scope of advanced registered nurse practitioner and physician assistant services as defined in the Kansas statutes.

(c) Services and related medical supplies furnished incident to professional services provided by a physician, advanced registered nurse practitioner, or physician assistant. These are services and supplies commonly furnished in physician offices under the direct supervision of a physician, advanced registered nurse practitioner, or physician assistant.

(d) Visiting nurse services. These are home health nursing services and related medical supplies provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse at the beneficiary's place of residence, which shall not include a hospital or long-term care facility, under all of the following conditions:

(1) The rural health clinic is located in an area where there is no home health agency.



(2) The services are furnished to a homebound individual who is confined to the individual's place of residence because of a medical condition.

(3) Services are provided under a written plan of treatment established by a physician, advanced registered nurse practitioner, or physician assistant and reviewed at least once every 60 days by a supervising physician.

(e) Other ambulatory services covered by a medicaid state plan.

(f) Referral for covered services not provided by the rural health clinic, to other practitioners enrolled as providers in the Kansas medical assistance program shall be covered.

(g) Screening and appropriate referral for the "kan be healthy" program shall be covered. This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Dec. 29, 1995; amended Jan. 1, 1999.)

**30-5-82a. Reimbursement for rural health clinic services.** Reimbursement for rural health clinic services and other ambulatory services covered by the Kansas medical assistance program shall be at reasonable cost pursuant to 42 CFR 447.371, effective September 30, 1986; 42 CFR Part 413, revised as of October 1, 1997; Section 4205 of the balanced budget act of 1997; and the provisions discussed in this regulation. (a) Reimbursement method. An interim rate per visit shall be paid to each rural health clinic, subject to a fiscal year-end retroactive cost settlement.

(b) Interim reimbursement rate per visit.

(1) Rate for independent rural health clinic. Each clinic shall be paid by the agency the all-inclusive reasonable cost rate per visit determined by the medicare carrier.

(A) Initial rate at enrollment. The medicaid payment rate shall be the current medicare rate.

(B) Rate changes. The interim payment rate of an independent rural health clinic shall be changed by the agency each time a rate change notification for that clinic is received from the medicare carrier.

(2) Rate for provider-based rural health clinic.

(A) Initial rate at enrollment. An estimated payment rate per visit that is no more than the medicare payment limit shall be set by the agency.

(B) Rate changes. After cost settlement of a

provider-based clinic, the interim payment rate shall be changed by the agency based on paragraph (d)(2)(B) below.

(c) Visit. A "visit" means a face-to-face encounter between a clinic patient and a health care professional as defined in K.A.R. 30-5-82. Encounters with more than one health professional or multiple encounters with the same health professional that take place on the same day shall constitute a single visit except when, after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

(d) Retroactive cost settlement. The allowable medicaid cost shall be determined by the agency, and this cost shall be compared by the agency to the total payments to determine the amount overpaid or underpaid for each cost-reporting period. "Total payments" shall include interim reimbursements, health connect Kansas case management payments, third party liability, and any other payment for covered services.

(1) Cost settlement for independent rural health clinic.

(A) Cost report. The audited medicare cost report of the independent rural health clinic received from the medicare carrier shall be used by the agency.

(B) Allowable Kansas medical assistance program cost. The allowable medicaid cost of an independent rural health clinic shall be obtained by applying the audited medicare reimbursement rate per visit to medicaid paid claims data. For independent rural health clinic providers with multiple locations, aggregate medicaid paid claims data for all clinics shall be used.

(2) Cost settlement for provider-based rural health clinic.

(A) Cost report. The audited medicare cost report of the health care organization of which the rural health clinic is a part shall be used by the agency. This cost report is provided by the medicare intermediary.

(B) Allowable Kansas medical assistance program cost. Pursuant to 42 CFR 413.9 (a) and Section 4205 of the balanced budget act of 1997, the allowable medicaid cost shall be the lowest of the following three amounts:

- (i) Cost computed by using the cost report;
- (ii) cost computed by applying medicare maximum rate; or
- (iii) billed charges.

(e) Fiscal and statistical records and audits.

The requirements in K.A.R. 30-5-118a(d) shall apply.

(f) This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended July 1, 1994; amended Jan. 1, 1999.)

**30-5-83. Scope of services for ambulatory surgical centers.** Coverage shall be limited to non-elective surgical services, except for sterilization operations or for participants in the Kan Be Healthy program. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended May 1, 1985; amended Jan. 2, 1989.)

**30-5-83a. Reimbursement for ambulatory surgical centers.** Reimbursement shall be made as a fee for service established by the secretary. No fee shall be paid in excess of reasonable cost or charges, whichever is less. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988.)

**30-5-84.** This rule and regulation shall expire on January 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended May 1, 1988; amended July 1, 1989; revoked Jan. 1, 1990.)

**30-5-84a.** This rule and regulation shall expire on January 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1986; amended May 1, 1988; revoked Jan. 1, 1990.)

**30-5-85. Scope of independent laboratory services.** The services of independent laboratories shall be available to program recipients if: (a) the laboratory has been certified by medicare to perform the services;

(b) the laboratory is independent from the office of the ordering physician; and

(c) the laboratory services are prescribed. (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.)

**30-5-85a. Reimbursement for independent laboratory services.** Reasonable fees as related to customary charges shall be paid for

independent laboratory services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. (Authorized by and implementing K.S.A. 1982 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983.)

**30-5-86. Scope of services by community mental health centers.** (a) Community mental health center services shall be available to program recipients in:

(1) Outpatient treatment programs licensed by mental health and retardation services;

(2) approved inpatient treatment programs;

(3) partial hospitalization programs approved by mental health and retardation services pursuant to K.A.R. 30-5-110 and certified to participate in medicare; and

(4) the recipient's private residence.

(b) (1) During a calendar year, outpatient psychotherapy shall be limited to 32 hours per recipient unless the recipient is a "Kan Be Healthy" program participant. Outpatient psychotherapy shall be limited to 40 hours per calendar year for each "Kan Be Healthy" program participant.

(2) Outpatient psychotherapy shall be covered, when medically necessary, and when provided concurrently with both targeted case management services and partial hospitalization services by the same provider.

(c) Four hours of psychological testing and evaluation shall be allowed every two consecutive calendar years for medicaid program recipients regardless of provider except that "Kan Be Healthy" program participants shall be allowed six hours. Admission evaluations shall not exceed five hours per calendar year and may include a physical examination.

(d) Inpatient psychotherapy shall be available pursuant to K.A.R. 30-5-81. Case conferences may be considered as individual therapy if they meet the definition in K.A.R. 30-5-58. Group therapy shall be reimbursable only if it is rendered on a day when group therapy has not been a part of partial hospitalization.

(e) Targeted case management services shall be limited to an amount per calendar year per recipient as specified by the secretary.

(f) Services shall be provided by a psychiatrist, a licensed psychologist with a doctoral degree or a registered master's level psychologist, master's degree social worker, master's degree psychiatric nurse, or individuals certified by the Kansas as-

sociation of community mental health center directors' professional standards committee and approved by the agency, unless the approval is contrary to law or regulation.

(g) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; modified, L. 1983, ch. 361, May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Aug. 1, 1990; amended July 1, 1991; amended Oct. 1, 1992; amended Jan. 4, 1993; amended Dec. 29, 1995.)

**30-5-86a. Reimbursement for community mental health centers.** Reasonable fees as related to customary charges shall be paid for community mental health center services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. The effective date of this regulation shall be July 1, 1988. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988.)

**30-5-86b. Existing provider rates for community mental health centers.** (a) For an existing provider and those providers resulting from a separation from or a division of an existing provider, the agency shall review the fee schedule retained for cost auditing and supplied annually to the agency by the provider to determine per hour rates. The rates shall be based on the patient-related costs submitted by the provider for its fiscal year ending on or before December 31, 1981, and any subsequent base years thereafter, as established by the secretary. The rate may be adjusted on or after each July 1 by an inflation factor established by the secretary. The rates shall be limited to the lesser of the computed rate, the highest fee charged to and paid by private patient resources within the catchment area, or the range maximums established by the secretary. Under no circumstances shall a separation or division from an existing provider be considered as the establishment of a new provider, and the existing rate shall be continued. A provider shall be reimbursed for recipients living outside their catchment areas

at the same rate as recipients located within their catchment areas.

(b) Failure to complete and submit any required cost report or other financial data shall result in that center's new reimbursement rate being reduced to the lowest rate paid to a community mental health center until such time that a cost report is received and reviewed by the division of medical programs. This rule and regulation shall expire on July 1, 1988. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1986; amended May 1, 1988.)

**30-5-86c. New provider rates for community mental health centers.** (a) Rates for the first 18 months of a new community mental health center shall be computed from projected costs. The first projection, based on 12-month projected cost data, shall apply to the first six months of operation. The second 12-month projection, based on six months' actual cost data, shall be filed within 60 days after the end of the sixth month. The projected rate shall remain in effect until a rate can be established from a cost report based on historical cost data for the last 12 months of the projection period. Failure to complete and submit the required cost report or other financial data shall result in that center's reimbursement rate being reduced to the lowest rate paid to a community mental health center.

(b) Each new provider shall file a cost report based on historical cost data for the 12-month period ending on the last day of the 18th month following licensure of the community mental health center. Retroactive adjustments of the payments made during the projection period shall be made at the end of the 18-month period after audit of the historical cost data. Settlement of an overpayment or underpayment shall be at the audited rate computed from the historical cost data reported in accordance with this paragraph, or at the highest fee charged to and paid by private patient resources within the catchment area, or at the range maximums established by the secretary, whichever is less.

(c) Rates for a new provider, subsequent to the projection period, shall be based on the historical cost data reported in accordance with subsection (b), adjusted by an inflation factor established by the secretary, to compute a rate comparable to the rates computed in K.A.R. 30-5-86b for existing providers. This rule and regulation shall expire on July 1, 1988. (Authorized by and implementing

K.S.A. 39-708c; effective May 1, 1986; amended May 1, 1988.)

**30-5-86d. Financial recordkeeping for community mental health centers.** (a) Records shall be maintained by the provider to document income and expenditures, hours of services provided, allocation methodologies, and fees charged to and paid by private patient resources.

(b) Each provider record used in support of costs, charges and payments for services and supplies shall be subject to inspection and audit by the agency, the United States department of health and human services, and the United States general accounting office. Standardized definitions, accounting, statistics and reporting practices which are widely accepted in community mental health centers and related fields shall be followed. This rule and regulation shall expire on July 1, 1988. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1986; amended May 1, 1988.)

**30-5-86e. Modification of prospective rates for community mental health centers.** (a) Each community mental health center participating in the prospective payment system may request that the rate review committee set forth in paragraph (g) modify its reimbursement rate if its current medicaid/medikan program unit cost exceeds the unit reimbursement rate by at least 15%.

(b) Each rate modification request shall be in writing, shall set forth sufficient information and documentation to support the request, and shall be received by the division of medical programs prior to April 1 of each year.

(c) The review committee shall submit its recommendations to the commissioner of income maintenance and medical services within 60 days after its receipt of the request.

(d) The commissioner shall have five working days from the receipt of the review committee's recommendations to accept, modify or reject them. The recommendations of the review committee shall become final if the commissioner fails to act within 60 days of the committee's receipt of the request.

(e) The commissioner shall notify the agency or community mental health center of the disposition of its modification request within five working days of the final decision.

(f) Each approved modification shall become effective on and after July 1 of that year.

(g) The secretary shall appoint a rate review committee consisting of six members and six alternates. Three of the members and three of the alternates shall be selected in consultation with the association of community mental health centers of Kansas. This rule and regulation shall expire on July 1, 1988. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1986; amended May 1, 1988.)

**30-5-87. Scope of the Kan Be Healthy program.** Kan Be Healthy screenings shall be available at intervals designated by the Kansas department of social and rehabilitation services and at other medically necessary intervals for all program recipients under 21 years of age. (a) The Kan Be Healthy medical screening shall include, but shall not be limited to, the following procedures:

(1) Comprehensive health and developmental history;

(2) comprehensive, unclothed physical examination;

(3) appropriate laboratory tests;

(4) appropriate immunizations according to age and health history;

(5) health education including anticipatory guidance; and

(6) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(b) The Kan Be Healthy dental screening shall include, but shall not be limited to, the following procedures:

(1) Comprehensive oral examination; and

(2) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(c) The Kan Be Healthy vision screening shall include, but shall not be limited to, the following procedures:

(1) A vision screening; and

(2) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(d) The Kan Be Healthy hearing screening shall include, but shall not be limited to, the following procedures:

(1) Appropriate hearing testing; and

(2) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(e) Diagnosis and treatment to correct defects and chronic conditions discovered during screen-



ing shall include, but shall not be limited to, the following services:

- (1) Eyeglasses;
- (2) relief of pain and infections, restoration of teeth and maintenance of dental health;
- (3) hearing aids; and
- (4) other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-6-1-90, June 1, 1990; amended Aug. 1, 1990.)

**30-5-87a. Reimbursement for Kan Be Healthy program services.** (a) Reimbursement for screening and appropriate referral shall be made as a fee for service established by the secretary. No fee shall be paid in excess of reasonable cost or charges, whichever is less.

(b) Reimbursement for diagnosis and treatment shall follow the guidelines established for all other provider groups in the program. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989.)

**30-5-88.** (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended, T-89-24, May 27, 1988; amended Sept. 26, 1988; amended, T-30-10-28-88, Oct. 28, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-7-29-89, July 29, 1989; amended Nov. 24, 1989; amended Aug. 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended July 1, 1996; amended July 1, 1998; revoked Jan. 12, 2007.)

**30-5-88a. Reimbursement for physician services.** (a) Reasonable fees as related to customary charges shall be paid for physician services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations.

(b) The maximum rate for services provided by a physician extender shall be 75% of that allowed for the physician who is billing for the physician extender services. (Authorized by and implementing K.S.A. 1982 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983.)

**30-5-89. Scope of home health services.**

(a) Covered home health services shall be available to program recipients if both of the following conditions are met:

(1) A physician has developed a plan of treatment and has certified the need for the service.

(2) The service is determined to be medically necessary pursuant to K.A.R. 30-5-58.

(b) Skilled nursing services that are provided on a part-time or intermittent basis shall be provided by a home health agency that meets the requirements for participation in medicare. If there is no such agency in the recipient's county of residence, skilled nursing services may be provided by a registered professional nurse who is licensed in Kansas.

(c) Except as specified in subsection (d), home health services shall be provided by an agency that meets the requirements to participate in medicare. Home health services shall include the following:

(1) Skilled nursing services provided by a registered professional nurse or a licensed practical nurse;

(2) home health aide services;

(3) restorative and rehabilitative physical therapy;

(4) restorative and rehabilitative occupational therapy;

(5) restorative and rehabilitative speech therapy;

(6) respiratory therapy for Kan Be Healthy program participants;

(7) immunizations;

(8) durable medical equipment and medical supplies pursuant to K.A.R. 30-5-108 and K.A.R. 30-5-166; and

(9) restorative aide services.

(d) Prior authorized medical attendant care for independent living (ACIL) by a licensed home health agency shall be covered for eligible beneficiaries.

(1) Covered services for the ACIL program shall consist of the following:

(A) Attendant care;

(B) skilled nursing care provided by a licensed

practical nurse or registered professional nurse; and

(C) case management.

(2) Covered services shall meet the following requirements:

(A) Continue as long as the recipient complies with the plan of care and meets the eligibility requirements for program participation set by the Kansas department of social and rehabilitation services;

(B) not be reimbursed if provided in the same 24-hour period as designated medicaid HCBS services; and

(C) be provided after a recipient is determined by the department to be eligible for the services. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended Jan. 1, 1990; amended Aug. 15, 2003.)

**30-5-89a. Reimbursement for home health services.** (a) Reimbursement shall be based upon the fee for services and at a rate established by the secretary.

(b) Reimbursement for medical supplies shall be pursuant to K.A.R. 30-5-108a. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended Aug. 15, 2003.)

**30-5-90.** This rule and regulation shall expire on August 1, 1990. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; revoked Aug. 1, 1990.)

**30-5-90a.** (Authorized by and implementing K.S.A. 1982 Supp. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; revoked May 1, 1986.)

**30-5-91.** (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1981; amended May 1, 1985; revoked May 1, 1986.)

**30-5-92. Scope of pharmacy services.** (a) The medical services provided to program recipients shall include pharmacy services.

(1) Kan Be Healthy participants shall be limited to those prescription-only and over-the-counter drugs, supplies, and devices that have been accepted for inclusion on any formulary list-

ing for Kan Be Healthy participants adopted and distributed by the secretary to eligible providers of service.

(2) Other medicaid recipients shall be limited to those prescription-only and over-the-counter drugs, supplies, and devices that have been accepted for inclusion on any formulary listing for other medicaid recipients adopted and distributed by the agency to eligible providers of service.

(b) Covered drugs, supplies, and devices shall be prescribed by the recipient's attending practitioner and dispensed in a pharmacy by a pharmacist, with the exception of those drugs, supplies, or devices designated by the secretary.

(c) Each provider of pharmacy services shall comply with the provisions of K.A.R. 30-5-59 and shall be assigned a pharmacy services provider number.

(d) (1) Each pharmacist shall dispense each brand-name legend drug as prescribed if either of the following conditions is met:

(A) The pharmacist receives a written prescription on which the prescriber has signed on the "dispense as written" signature line or has personally handwritten "dispense as written" or "D.A.W." on the prescription.

(B) The pharmacist receives an oral prescription in which the prescriber has expressly indicated that the prescription is to be dispensed as communicated.

(2) Each pharmacist shall dispense the generic form of a prescribed brand-name drug, after disclosing the substitution to the consumer, if all of the following conditions are met:

(A) The pharmacist receives either of the following:

(i) a written prescription on which the prescriber has neither signed on the "dispense as written" signature line nor personally handwritten "dispense as written" or "D.A.W." on the prescription; or

(ii) an oral prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated.

(B) There is available in the pharmacist's stock a less expensive generic drug that is rated bioequivalent (AB-rated) by the food and drug administration.

(C) In the pharmacist's professional judgment, the generic drug is safely interchangeable with the prescribed drug.

A pharmacist may also make a substitution in a manner consistent with the oral instructions of the

prescriber. The pharmacist shall notify the consumer if the pharmacist is dispensing a drug other than the brand-name drug prescribed.

(3) If more than one safely interchangeable generic drug is available in the pharmacist's stock, then the pharmacist shall dispense the least expensive alternative.

(4) Nothing in this subsection shall be deemed to require a pharmacist to substitute a generic drug if the substitution will make the transaction ineligible for reimbursement.

(5) If a pharmacist dispenses a brand-name legend drug and, at that time, a less expensive generic drug is also available in the pharmacist's stock, the pharmacist shall disclose to the consumer that a generic drug is available.

(e) If a drug product is issued to a patient of a long-term care facility and subsequently is not used, the long-term care facility shall return the drug product to the vendor pharmacy for repackaging and crediting to the secretary if the drug product meets all of the following conditions:

(1) The drug product is a prescription drug product that is not a controlled substance.

(2) The drug product is sealed in individually packaged units or in a multiple-dose, sealed container approved by the federal food and drug administration from which no doses have been withdrawn.

(3) The drug product is returned to the vendor pharmacy at least 90 days before the expiration date.

(4) The drug product is determined to be of acceptable integrity by a licensed pharmacist.

(f) Each long-term care facility shall establish procedures for the return of unused drug products to the vendor pharmacy from which the unused drug products were received.

(g) Each provider of pharmacy services may be reimbursed the reasonable cost of returning and crediting unused drug products, as determined by the secretary.

(h) After prior notification of each provider, reimbursement under the program may be denied for any of the following:

(1) Certain drugs, supplies, and devices determined by the secretary to be less than effective;

(2) drugs, supplies, and devices that do not meet the requirements of section 1927 of the social security act, 42 U.S.C. 1396r-8, as amended Nov. 29, 1999, which is adopted by reference, pertaining to available rebates or the medical necessity of the drug, supply, or device; or

(3) drugs, supplies, or devices restricted by the secretary under the provisions of section 1927 of the social security act, 42 U.S.C. 1396r-8 regarding permissible restrictions.

Selected drugs, supplies, and devices shall be considered for coverage only when prior authorization criteria are met.

(i) Pharmacy services provided for parenteral administration of total nutritional replacements in the consumer's home shall not be covered through the pharmacy program and shall be billed through the durable medical equipment program.

(j) The total number of prescriptions that any recipient may receive in a given time period shall be limited as determined by the secretary.

(k) Selected pharmacy services shall be limited to a dollar value for a given time period as determined by the secretary. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended Jan. 2, 1989; amended Aug. 1, 1990; amended May 1, 1991; amended July 6, 2001.)

**30-5-93.** (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981; revoked May 1, 1985.)

**30-5-94. Reimbursement for pharmacy services.** (a) Each pharmacy provider shall be reimbursed for covered pharmacy services on the basis of product acquisition cost plus a dispensing fee. In no case shall reimbursement for a prescription exceed the lesser of the provider's usual and customary charge for that prescription or the state allowable for that prescription. The submitted charge and payment for covered over-the-counter pharmacy products shall not exceed the lesser of the product acquisition cost plus the dispensing fee or the usual and customary over-the-counter charge of the pharmacy provider.

(b) The acquisition cost shall include a maximum allowable cost for selected multiple-source drugs as determined by the secretary.

(c) The dispensing fee assigned to pharmacy providers shall be \$3.40 per prescription unless a different rate is established by the secretary.

(d) If an inactive pharmacy wishes to become an active provider, the pharmacy shall reapply according to K.A.R. 30-5-59.

(e) In areas in which pharmacy services are not available, each physician dispensing prescriptions to consumers shall be eligible to receive reimbursement for provision of those services after a

pharmacy provider number has been issued by the department according to K.A.R. 30-5-59.

(1) Each physician assigned a pharmacy provider number shall be reimbursed on the basis of product acquisition cost plus a dispensing fee of \$.74 per prescription.

(2) The physician shall not be reimbursed a dispensing fee for injectable drugs administered in the office, except as included in the charge for the professional services of the physician.

(f) Each pharmacy provider shall be reimbursed only when the covered service has been prescribed by the consumer's attending practitioner.

(g) This regulation shall be effective on and after December 31, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended July 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended May 1, 1991; amended Dec. 29, 1995; amended Oct. 1, 1997; amended July 6, 2001; amended Dec. 31, 2002.)

**30-5-95. Cost report requirement for pharmacy services.** (a) The cost reports filed by pharmacy providers for professional fee determination shall reflect data which coincides with the immediate fiscal year used for federal income taxes that ends prior to the cost report filing due date, except in those cases where the provider is not required to file a federal income tax return. In such cases, the provider shall file a cost report from the official financial reporting records of the business.

(b) (1) A pharmacy shall have been in operation for at least six months in the cost reporting period and have submitted at least 250 medicaid prescription claims annually during the cost reporting period at fiscal year end, to file an initial cost report.

(2) Any Kansas pharmacy that fails or refuses to file a cost reports when required shall not be assigned a professional fee.

(3) Any pharmacy that does not receive a professional fee as a result of failure or refusal to file cost reports shall have a professional fee calculated and assigned following the completion of the next report as required by the department. The assignment of such a professional fee will take effect at the same time all professional fees of pharmacies are adjusted through the standard fee set-

ting procedures of the department. If all pharmacy fees are not adjusted through the standard fee setting procedures of the department, the pharmacy shall be assigned a fee that corresponds to the average fee in effect at the time the pharmacy submits the cost report. The assignment of a fee to a pharmacy which previously failed or refused to file a cost report shall take effect at a date set by the secretary. There shall be no retroactive cost adjustment or settlement.

(c) Cost report and prescription survey forms, instructions, and notice of the requirement to file shall be prepared by the Kansas department of social and rehabilitation services and distributed to all pharmacy providers as required.

(d) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1981; amended May 1, 1984; amended May 1, 1987; amended July 1, 1989; amended May 1, 1991; amended April 1, 1992; amended Dec. 29, 1995.)

**30-5-96. Cost report data and record keeping requirements for pharmacy services.**

(a) The principles of cost related reimbursement require that providers maintain sufficient financial and prescription records to facilitate appropriate cost reporting and professional fee determination. Standardized definitions, accounting, statistics, record keeping and reporting practices which are widely accepted in pharmacy practice and related fields shall be adhered to. Significant modifications in these practices and systems shall not be required in order to determine costs pertinent to the principle of cost related reimbursement.

(b) The pharmacy provider shall keep and make available for review, upon request of the agency, the supporting records and documents as are necessary to ascertain that the cost related professional fee determination and program payments are appropriate. These records shall include matters regarding pharmacy ownership and organizational structure; fiscal and prescription record keeping systems; lease and acquisition agreements; state and federal income tax returns with all supporting documents; drug product, devices and supply purchase invoices; asset acquisition, lease or sale; franchise or management arrangements; pharmacy services charge schedules; income receipts by source and purpose; and records pertaining to all other reported costs of op-



eration on the cost study report. Other records shall be made available as necessary. Pertinent records shall be maintained by the pharmacy provider for five (5) years from the date of filing the corresponding cost report with the agency. Records in support of costs, charges and payments for services and products are subject to inspection and audit by the agency and the United States department of health and human services. If a pharmacy provider does not maintain adequate records to support cost related professional fee determination, the assigned professional fee to that provider shall be suspended or reduced to the lowest fee determined for all participating pharmacy providers that filed a cost report for the period of inadequate records. Program payments to such providers shall be suspended or reduced until the agency is assured that adequate records are maintained.

(c) Cost reports filed by pharmacy providers shall reflect cost data provided in accordance with generally accepted accounting principles, and in adequate detail to permit recasting of the costs derived from the accounts ordinarily kept by the provider to ascertain the costs pertinent to various facets of the total pharmacy operation. The data, including source documentation, shall be accurate for the appropriate reporting period and sufficient to support cost related professional fee determination. (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.)

**30-5-97. Cost report data limitations and allowances for pharmacy services.** (a) Allowable costs for cost related reimbursement and professional fee determination shall be limited to those that arise from arms length transactions between unrelated parties. Related parties shall exist when one (1) party of a transaction has the ability to significantly influence another party to the extent that their own separate interests may not be fully pursued.

(1) Costs not related to the provision of pharmacy services shall be disallowed in the computation of the professional fee. Related costs shall be allowed in total, fractionally allocated or limited in the professional fee computation process per cost finding and allocation techniques employed in the analysis of pharmacy cost reports.

(2) The following costs shall be disallowed, fractionally allocated or limited in the analysis of cost reports:

(A) transactions between related parties are

disallowed as costs (*i.e.*, non-arms length transactions), except that compensation received by owners shall be limited to a reasonable amount and accepted as an allowable cost if the owner actually performs functions directly related to the provision of pharmacy services. The reasonable limitation of an owner's compensation shall take into consideration the costs that would have been incurred to pay a non-owner employee for performance of the duties related to the provision of pharmacy services;

(B) costs deemed unreasonable by comparison with similar costs incurred by similar pharmacy providers may be limited or disallowed;

(C) non-competition covenant expenses are not allowable as costs for professional fee determination; and

(D) corporate officer's fees shall be considered as owner's compensation and subject to the limitations applicable to owner's compensation.

(3) Nothing in this section shall preclude application of reasonable limitations on any other specific cost data items as considered appropriate by the agency.

(b) Audit findings and conclusions per review of pharmacy provider cost reports and subsequent professional fee determinations which reveal overpayment by the agency for pharmacy services shall be subject to refund to the agency by such pharmacy providers. Audit activities which reveal underpayment by the agency to pharmacy providers shall be subject to adjustment payment by the agency to such providers.

(c) Insufficient documentation to support payment for services provided as reflected on billings submitted to the agency by pharmacy providers shall result in suspension or denial of program payments to such provider pending verification of documentation to support the billed charges. (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.)

**30-5-98 and 30-5-99. Reserved.**

**30-5-100. Scope of dental services.** (a) Dental services shall be covered for recipients receiving a Kan Be Healthy dental screening.

(1) Both a Kan Be Healthy medical screening and a Kan Be Healthy dental screening shall be required for coverage of limited orthodontia services, with the exception of emergency services.

(2) Prior authorization shall be required for designated services.

(3) Prior authorization shall be required for

dental treatment plans estimated to exceed, during a calendar year, the range maximum established by the secretary.

(b) Dental services for medicaid recipients not participating in the Kan Be Healthy program shall be limited to the following treatments:

- (1) Ocrantral fistula closure;
- (2) unilateral radical antrotomy;
- (3) biopsy of oral tissue;
- (4) radical excision of lesion;
- (5) excision of tumors;
- (6) removal of cysts and neoplasms;
- (7) partial ostectomy;
- (8) surgical incision and drainage of abscess;
- (9) removal of foreign bodies, skin, subcutaneous areolar tissue;
- (10) sequestrectomy for osteomyelitis;
- (11) maxillary sinusotomy for removal of tooth fragment or foreign body;
- (12) treatment of fractures;
- (13) closed reduction of dislocation and related injections;
- (14) limitation of motion and related injections;
- (15) sutures;
- (16) oral skin grafts;
- (17) frenulectomy;
- (18) excision of pericoronal gingiva;
- (19) sialolithotomy;
- (20) excision of salivary gland;
- (21) sialodochoplasty;
- (22) closure of salivary fistula;
- (23) emergency tracheotomy;
- (24) general anesthesia: first 30 minutes;
- (25) general anesthesia: each additional 15 minutes;
- (26) consultation in the form of diagnostic services provided by a dentist or physician other than the practitioner providing treatment;
- (27) house call or extended care facility call;
- (28) hospital call; and
- (29) prior authorized procedures for medically necessary tooth extractions.

(c) This regulation shall be effective on and after January 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-84-7, May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Oct. 1, 1989; amended Aug. 1, 1990; amended

Dec. 31, 1992; amended Sept. 27, 1993; amended Jan. 1, 2002.)

**30-5-100a. Reimbursement for dental services.** Reimbursement shall be made on the basis of reasonable charges, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. The sum of payments per Kan Be Healthy recipient for dental services provided during each fiscal year beginning July 1, 1987, shall be limited to an amount specified by the secretary. Prior authorization shall be obtained before exceeding this payment limit. The effective date of this regulation shall be December 31, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective May 1, 1981; amended May 1, 1987; amended Dec. 31, 1992.)

**30-5-101.** (Authorized by and implementing K.S.A. 1996 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended Jan. 2, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended Jan. 7, 1991; amended, T-30-8-9-91, Aug. 9, 1991; amended Oct. 28, 1991; amended Jan. 1, 1997; amended July 1, 1997; revoked June 28, 2002.)

**30-5-101a.** (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; revoked Dec. 27, 2002.)

**30-5-102. Scope of optometric and optical services.** Optometric and optical services shall be covered for medicaid recipients. (a) These services shall include the following:

- (1) Optometric examinations;
- (2) medical treatment pursuant to K.S.A. 65-1501, and amendments thereto;
- (3) grinding and edging lenses, and assembling and dispensing eyeglasses; and
- (4) providing optical materials. Optical materials shall include the following:

(A) Frames. The materials covered shall be only frames showing the manufacturer's name on either the front or temple; and

(B) lenses. Only lenses meeting designated standards shall be acceptable. For single lens re-

placement, the replacement lens shall be made of quality similar to that of the remaining usable lens.

(b) Limitations.

(1) Prior authorization shall be required for designated services.

(2) The second and subsequent sets of eyeglasses shall meet the standards specified by the secretary.

This regulation shall be effective on and after January 1, 2004. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended, T-30-1-2-03, Jan. 2, 2003; amended April 18, 2003; amended Jan. 1, 2004.)

**30-5-102a. Reimbursement for optometric and optical services.** Reimbursement for covered services shall be made on the basis of reasonable charges, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

**30-5-103. Scope of podiatric services.** Podiatric services shall be covered for Kan Be Healthy program participants. (a) Covered services shall be diagnosis and the manual, medical, surgical or pharmaceutical treatment of those parts of the body below the ankle. Diagnosis and treatment of tendons and muscles of the lower leg as they relate to conditions of the foot shall also be covered.

(b) Surgery shall be limited to that performed on an outpatient basis.

(c) Routine foot care shall not be covered. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1981; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended Jan. 7, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

**30-5-103a. Reimbursement for podiatric services.** Reimbursement for covered services shall be made on the basis of reasonable charges, except that a fee in excess of the range maximum shall not be paid. (Authorized by and implement-

ing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986.)

**30-5-104. Scope of psychological services.** Psychological services shall be covered for medicaid recipients when provided by clinical psychologists who are licensed by the behavioral sciences regulatory board. (a) Psychotherapy services shall be limited to 40 hours per calendar year for Kan Be Healthy program participants.

(b) Psychotherapy services shall be limited to 32 hours per calendar year for those not participating in the Kan Be Healthy program.

(c) Psychotherapy shall not be covered when provided concurrently by the same provider with both partial hospitalization and case management.

(d) Special psychological services for Kan Be Healthy program participants shall be rendered pursuant to a plan approved by the Kansas department of social and rehabilitation services. The plan shall require prior authorization, and shall not exceed a two-year period. Quarterly progress reports shall be submitted to the department upon request.

(e) Inpatient hospital visits shall be limited to those visits ordered by the recipient's physician, and shall not exceed those allowable days for which the hospital is paid or would be paid if there were no spenddown requirements.

(f) Visits to nursing facilities by the psychologist as part of the plan of care shall be ordered by the recipient's physician. Visits to intermediate care facilities for mental retardation shall be limited to psychological testing and evaluation. Visits to nursing facilities for mental health shall be limited to program consultation.

(g) Four hours of psychological testing and evaluation shall be allowed every two consecutive calendar years for medicaid program recipients regardless of provider except that Kan Be Healthy program participants shall be allowed six hours. The effective date of this regulation shall be July 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708; effective May 1, 1981; amended May 1, 1982; modified, L. 1983, ch. 361, May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Aug. 1, 1990; amended Jan. 2, 1991; amended July 1, 1991.)

**30-5-104a. Reimbursement for psychologists services.** Reimbursement shall be

made on the basis of reasonable charges, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.)

**30-5-105. Scope of hearing services.**

Hearing services shall be covered for medicaid recipients. (a) Medical diagnosis, audiological testing, and the fitting and dispensing of hearing aids and appropriate accessories shall be covered.

(b) A medical diagnosis shall be made by an ear specialist or by a general practitioner if an ear specialist is not easily available.

(c) Audiological testing shall be performed by a physician or an audiologist.

(d) Fitting, dispensing, and follow-up shall be performed by a hearing aid dealer.

(e) A hearing aid shall not be covered if the physician indicates that a medical condition contraindicates the effectiveness of an aid.

(f) This regulation shall be effective on and after January 1, 2004. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended Oct. 1, 1993; amended, T-30-1-2-03, Jan. 2, 2003; amended April 18, 2003; amended Jan. 1, 2004.)

**30-5-105a. Reimbursement for hearing services.** Reimbursement for hearing services and for the fitting and dispensing of hearing aids, accessories, and follow-up service shall be made on the basis of reasonable charges, except that a fee in excess of the range maximum shall not be paid. The range of charges shall provide the base for computations. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

**30-5-106. Scope of ambulance services.**

(a) General provisions of coverage. Ambulance services shall be available to program recipients. Services shall include the following:

(1) emergency transportation to a facility where medical services will be rendered; and

(2) non-emergency transportation of a recipient between the recipient's residence and a medical facility in the recipient's local community or the nearest facility able to render the medically necessary services, and transportation of a patient from one medical facility to another medical facility when the original facility provides inadequate

services for treating the patient. Transportation under this paragraph shall require prior authorization for designated services.

(b) Limitations.

(1) The ambulance service shall be licensed.

(2) The recipient's condition shall be such that the use of any other method of transportation is not possible without endangering the health of the recipient.

(3) The use of licensed ambulances for non-emergency wheelchair transportation shall not be covered.

(4) Non-emergency ambulance transportation of a nursing facility resident shall not be covered.

(c) The effective date of this regulation shall be April 1, 1995. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended April 1, 1995.)

**30-5-106a. Reimbursement for ambulance services.** Reasonable fees as related to customary charges shall be paid for ambulance services. However, no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988.)

**30-5-107. Scope of non-emergency medical transportation services.** (a) Non-commercial transportation, including wheelchair transportation, to and from medicaid-covered services, shall require prior authorization except for trips to receive emergency care. Services shall be provided only when transportation is not otherwise available to the recipient.

(b) The least expensive means of transportation suitable to the recipient's medical need shall be used.

(c) Non-emergency medical transportation for nursing facility residents shall not be covered.

(d) This regulation shall be effective on and after July 1, 2003. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended April 1, 1995; amended Oct. 1, 1997; amended July 1, 2003.)

**30-5-107a. Reimbursement for non-emergency medical transportation services.**



(a) Non-commercial, non-emergency medical transportation providers shall be paid 22 cents per mile.

(b) Each commercial, non-emergency medical transportation provider shall be reimbursed at one of the following rates:

(1) For level one general transportation, \$10.00 for each one-way trip to a medicaid-covered service for a medicaid beneficiary, plus \$1.00 per mile after 10 miles; or

(2) for level two transportation for a non-ambulatory medicaid beneficiary, transportation of medical equipment with a medicaid beneficiary, or transportation of a medicaid beneficiary following a treatment that will result in a disabling physical condition, \$20.00 for each one-way trip to a medicaid-covered service for a medicaid beneficiary plus \$1.00 per mile after 10 miles.

(c) Reimbursement for necessary meals and lodging may be allowed for Kan Be Healthy participants and one attendant, subject to prior authorization.

(d) This regulation shall be effective on and after July 1, 2003. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended July 1, 2003.)

**30-5-108.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-84-26, Oct. 19, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended Jan. 2, 1989; amended July 1, 1989; amended May 1, 2001; revoked Nov. 17, 2006.)

**30-5-108a. Reimbursement for durable medical equipment, medical supplies, orthotics, and prosthetics.** (a) Reimbursement for covered services shall be made on the basis of rates established by the secretary.

(b) Reimbursement for used equipment or repairs of equipment shall not exceed 75% of the reimbursement rate for new equipment.

(c) This regulation shall be effective on and after December 31, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended Dec. 31, 2002.)

**30-5-109. Scope of services in free-standing inpatient psychiatric facilities.** (a) Services shall be available to program recipients who are 65 and over if the services are provided

by a facility that meets the medicare requirements.

(b) Services shall be available to program recipients who are under 21 years of age if the services are provided by a facility accredited by the joint commission on accreditation of hospitals.

(c) Services for recipients under age 21 shall be rendered before the recipient reaches age 21 or, if the recipient was receiving the services immediately before reaching the age of 21, before the earlier of the following:

(1) The date the recipient no longer requires the services; or

(2) the date the recipient reaches the age of 22.

(d) Free-standing inpatient psychiatric facility admissions for persons under 21 shall be certified by an interdisciplinary team. This certification shall include documentation that the team has evaluated the patient, considered all local community resources for ambulatory care, and concluded that none of the available resources meet the patient's treatment needs.

(e) This regulation shall take effect on and after July 1, 1997. (Authorized by and implementing K.S.A. 1996 Supp. 39-708c; effective May 1, 1982; amended May 1, 1983; amended July 1, 1997.)

**30-5-109a. Reimbursement for free-standing psychiatric facilities.** Reimbursement for free-standing psychiatric facilities shall be pursuant to K.A.R. 30-5-81b as a general hospital. The effective date of this regulation shall be October 1, 1993. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1982; amended Oct. 1, 1993.)

**30-5-110. Scope of partial hospitalization programs.** (a) Partial hospitalization services shall be provided in a community mental health center or a facility affiliated with a community mental health center. The only exception to this is "Kan Be Healthy" program participants who may receive services in either an affiliated or non-affiliated partial hospitalization program.

(b) Supportive partial hospitalization services shall be limited to a specified number of hours per year.

(c) Partial hospitalization services provided by state institutions shall be exempt from any limitations of hours per recipient per calendar year.

(d) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective

May 1, 1983; amended, T-84-7, May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended Aug. 1, 1990; amended Oct. 28, 1991; amended May 1, 1992; amended Dec. 29, 1995.)

**30-5-110a. Reimbursement for partial hospitalization programs.** Reasonable fees as related to customary charges shall be paid for partial hospitalization program services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988.)

**30-5-111.** This rule and regulation shall expire on January 2, 1991. (Authorized by and implementing K.S.A. 1985 Supp. 39-777, 39-778; effective, T-84-25, Oct. 1, 1983; effective May 1, 1984; amended May 1, 1986; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; revoked Jan. 7, 1991.)

**30-5-112. Scope of local health department services.** (a) Local health department services shall be covered for medicaid/medikan recipients.

(b) Covered services shall include the following:

- (1) Kan Be Healthy program services;
- (2) family planning services;
- (3) maternal and child health services;
- (4) home health nursing services when home health agency services are not available to the recipient;
- (5) immunizations;
- (6) nursing assessments performed by a registered nurse; and
- (7) services to detect, diagnose and treat specific diseases. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989.)

**30-5-112a. Reimbursement for local health department services.** Reasonable fees, as related to customary charges, shall be paid for local health department services, except that no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations of the reimbursement. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1987.)

**30-5-113. Scope of advanced registered nurse practitioner and registered nurse anesthetist services.** (a) Advanced registered nurse practitioner services shall be covered for medicaid/medikan recipients when provided by an advanced registered nurse practitioner who is certified pursuant to K.A.R. 60-11-103 or who meets criteria in K.A.R. 60-11-103 if practicing out-of-state. Covered services shall be pursuant to K.A.R. 30-5-88.

(b) Registered nurse anesthetist services shall be covered for medicaid/medikan recipients when provided by a registered nurse anesthetist who is authorized to practice pursuant to K.S.A. 1989 Supp. 65-1151 and 65-1152. Anesthesia services shall be covered. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990.)

**30-5-113a. Reimbursement for advanced registered nurse practitioner and registered nurse anesthetist services.** The maximum rate for a service provided by an advanced registered nurse practitioner or a registered nurse anesthetist shall be one of the following: (a) When the services may be provided by a physician, the rate shall be 75% of that allowed for the physician, except for anesthesia services and Kan Be Healthy screenings; or

(b) other services shall be based upon reasonable fees as related to customary charges, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1988; amended Aug. 1, 1990.)

**30-5-114. Scope of targeted case management services.** (a) Targeted case management services shall be covered for medicaid/medikan recipients.

(b) Covered services shall include the following:

- (1) Referral for assessment;
  - (2) referral for treatment if appropriate according to the assessment; and
  - (3) assistance with gaining access to medically necessary services.
- (c) Mental retardation targeted case manage-

ment services shall be provided by mental retardation centers as defined in K.S.A. 19-4001 to 19-4005, inclusive, or agencies specifically designated by a mental retardation center to provide these services to individuals who are mentally retarded or developmentally disabled.

(d) Targeted nurse case management services for eligible medicaid recipients with at least one prior hospitalization for a high cost, high risk condition, and who are not eligible for any other medicaid case management services except the primary care network (PCN) services shall be provided by registered nurses in Sedgwick county only. Covered services shall include the following:

- (1) Referral for assessment or performance of assessment;
- (2) referral for treatment if appropriate according to the assessment; and
- (3) assistance with gaining access to and coordination of medically necessary services. The effective date of this regulation shall be October 1, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c; effective May 1, 1988; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-6-10-91, July 1, 1991; amended Oct. 28, 1991; amended Oct. 1, 1992.)

**30-5-114a. Reimbursement for targeted case management services.** Reasonable fees as related to customary charges shall be paid for targeted case management services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1988.)

**30-5-115. Scope of hospice services.** Hospice services shall be covered for medicaid and medikan recipients who have been determined to be terminally ill by a physician and who have filed an election statement with a hospice enrolled to participate in the medicaid/medikan program. Hospice services shall be covered pursuant to Public Law 99-272, section 9505, effective April 7, 1986. Medicaid eligible individuals who reside in adult care facilities shall have room and board reimbursed. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989; amended, T-30-12-28-29, Jan. 1, 1990; amended, T-30-12-28-90, Feb. 28, 1990; amended Aug. 1, 1990.)

**30-5-115a. Reimbursement for hospice services.** Reasonable fees as related to the medicare standards of hospice reimbursement as established pursuant to Public Law 99-272, section 9505, effective April 7, 1986, shall be paid for hospice services. The effective date of this regulation shall be July 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989.)

**30-5-116. Scope of rehabilitation services.** Rehabilitation services shall be covered for medicaid recipients when provided by providers enrolled pursuant to K.A.R. 30-5-59. These services may include the following: (a) Substance abuse treatment provided by an enrolled alcohol and drug addiction community service provider;

(b) behavior management services provided by an enrolled behavior management provider, including the following:

(1) Family mental health treatment services that have received prior authorization from a provider recommended by either the juvenile justice authority or the department's division of children and family policy;

(2) group mental health treatment services that have received prior authorization from a provider recommended by either the juvenile justice authority or the department's division of children and family policy;

(3) in-home, family-based mental health services that have received prior authorization from a provider recommended by either the juvenile justice authority or the department's division of children and family policy; and

(4) comprehensive evaluation and transition services for children who have special psychological or emotional, developmental, or health needs directed toward placement of the recipient in the least restrictive environment;

(c) psychological services, audiological services, Kan Be Healthy screenings, physical therapy, speech pathology or occupational therapy services provided to recipients when medically necessary for purposes of screening and evaluation and for providing services pursuant to an individualized educational plan or individualized family service plan and when provided by employees or contractors of enrolled local education agencies; and

(d) long-term head injury rehabilitation provided by an enrolled head injury rehabilitation facility. Long-term head injury rehabilitation shall be limited to only those individuals who meet the following criteria:

- (1) Have sustained a traumatic head injury;
  - (2) continue to show progress in their recovery;
- and
- (3) can benefit from transitional living skills training.

This regulation shall be effective on and after January 1, 2004. (Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended, T-30-10-2-91, Oct. 2, 1991; amended Jan. 2, 1992; amended July 1, 1994; amended Sept. 1, 1995; amended Jan. 1, 2004.)

**30-5-116a. Reimbursement for rehabilitation services.** (a) Reimbursement for substance abuse treatment and long-term head injury rehabilitation shall be based upon a negotiated rate pursuant to a contract between the Kansas department of social and rehabilitation services and a provider.

(b) Reimbursement for inpatient rehabilitation services provided in a general hospital shall be based on the diagnosis related group system.

(c) Reasonable fees as related to customary charges shall be paid for other rehabilitation services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. The effective date of this regulation shall be October 1, 1993. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective July 1, 1989; amended Jan. 7, 1991; amended, T-30-10-2-91, Oct. 2, 1991; amended Jan. 2, 1992; amended Oct. 1, 1993.)

**30-5-117. Scope of maternity center services.** Maternity center services shall be covered when provided by a maternity center licensed by the Kansas department of health and environment or its equivalent when provided by a maternity center located out of state. Labor and delivery shall be covered. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective Aug. 1, 1990.)

**30-5-117a. Reimbursement for maternity center services.** Reasonable fees as related to customary charges shall be paid for maternity center services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations. The effective date of this regulation shall be August 1,

1990. (Authorized by an implementing K.S.A. 39-708c; effective Aug. 1, 1990.)

**30-5-118.** (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Jan. 1, 1999; revoked June 2, 2006.)

**30-5-118a. Reimbursement for federally qualified health center services.** Reimbursement shall not exceed the reasonable cost of federally qualified health center services and other ambulatory services covered under the Kansas medical assistance program. "Reasonable cost" consists of necessary and proper cost incurred by the provider in furnishing covered services to program beneficiaries, subject to the cost principles and limits discussed in K.A.R. 30-5-118b, and paragraphs (b)(2)(C) and (c)(5) of this regulation. (a) Reimbursement method. An interim per visit rate shall be paid to each federally qualified health center provider, with a retroactive cost settlement for each facility fiscal year.

(1) Interim reimbursement rate. The source and the method of determination of interim rate shall depend on whether the federally qualified health center is a new enrollee of the Kansas medical assistance program, or is a previously enrolled provider. Under special circumstances, the interim rate may be negotiated between the agency and the provider.

(A) Newly enrolled facility. The initial payment rate shall be based on the average of the current reimbursement rates for previously enrolled federally qualified health center providers. If the facility is an already-established federally qualified health center with an available medicare cost report, an all-inclusive rate derived from the cost report may be used for setting the initial medicaid interim payment rate.

(B) Previously enrolled facility. After the facility submits a federally qualified health center cost report, the agency shall determine the maximum allowable medicaid rate per visit as discussed in K.A.R. 30-5-118a(c). This rate shall be the new interim payment rate for the facility.

(2) Visit. A "visit" means face-to-face encounter between a center patient and a center health care professional as defined in 30-5-118. Encounters with more than one health professional or multiple encounters with the same health professional that take place on the same day shall constitute a single visit, except when the patient suf-



fers illness or injury requiring additional diagnosis or treatment after the first encounter.

(3) Retroactive cost settlement. For each reporting period, the agency shall compare the total maximum allowable medicaid cost with the total payments to determine the program overpayment or underpayment. Total payments shall include interim payments, healthconnect payments, third party liability, and any other payments for covered federally qualified health center services. The cost report and supplemental data submitted by the provider, medicare cost report, and the medicaid paid claims data obtained from the program fiscal agent shall be used for these calculations.

(b) Cost reporting. Each federally-qualified health center shall submit a completed cost report. The form used for cost reporting shall be the most current version of Form HCFA-222-92 (revised July 1994), the medicare financial and statistical report form for independent rural health clinics and freestanding federally qualified health centers.

(1) Filing requirements. Each provider shall be required to file annual cost reports on a fiscal year basis. In some instances, the report period may be shorter or longer than 12 months including for a newly opened facility.

(A) Cost reports shall be received no later than five months after the end of the facility's fiscal year. An extension in due date may be granted by the agency upon request, if necessary due to circumstances beyond control.

(B) Each provider filing a cost report after the due date without preapproved extension shall be subject to penalties listed below:

(i) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider may be withheld and suspended until the complete financial and statistical report has been received.

(ii) Failure to submit the completed financial and statistical report within one year after the end of the cost report period may be cause for termination from the Kansas medical assistance program.

(2) Fiscal and statistical data. The preparation of the cost report shall be based upon the financial and statistical records of the facility, and shall use the accrual basis of accounting. The reported data shall be accurate, sufficient by detailed, and adequately supported to facilitate verification and analysis for the determination of allowable costs.

(A) Non-allowable programs and costs. Ex-

penses not necessary for the efficient delivery of federally qualified health center services and not related to patient care shall not be reported as allowable costs. The provider shall separate non-federally qualified health center programs and non-reimbursable expenses from the allowable direct and indirect federally qualified health center costs, and shall report them in the designated sections of the cost report. Cost principles applicable to federally qualified health center services are discussed in K.A.R. 30-5-118b.

(B) Purchase discounts, allowances, rebates, and expense recoveries. Any expenditure for which the provider received a purchase discount, allowance, rebate, or reimbursement shall be reported net of the cost reduction adjusted on the cost report by subtracting the cost reduction on the appropriate expense line.

(C) Adjusted total visits. The total number of visits shall be reported by health care professional categories and adjusted by applying productivity screens to selected categories as listed below:

(i) Physician visits. A productivity standard of 4,200 hours shall be used for reporting all physician visits, except those attributable to "Physician Services Under Agreement."

(ii) Physician assistant, nurse practitioner, and dental visits. A minimum standard of 2,100 hours shall be used as a productivity screen for adjusting these visits on the cost report.

(3) Supplemental data. The following additional information shall be submitted to support reported data and to facilitate cost report review, verifications, and other analysis.

(A) A working trial balance. It shall contain account numbers, descriptions of the accounts, the amount of each account, the cost report expense line on which the account was reported, and fiscal year-end adjusting entries to facilitate reconciliation between the working trial balance and the cost report. The facility shall bear the burden of proof that the reported data accurately represents the cost and revenue as recorded in the accounting records. Any unexplained differences shall be used to reduce the allowable cost.

(B) The financial statements and management letter prepared by the facility's independent auditors. These statements shall also reconcile with the cost report.

(C) An itemized list of revenues received by the provider shall be submitted, if not already included in paragraph (b)(3)(A) or (B) above.

(i) For each grant, gift, donation, or endow-

ment that is designated by the donor for a specific program or operating cost, the designated purpose shall be clearly indicated.

(ii) Both federal share and the state or local match shall be reported for each grant. Otherwise, the cost report shall be considered incomplete.

(iii) Revenue with no indication of their nature or purpose, including "other income" or "miscellaneous revenue," shall be properly explained. Any items without adequate explanation shall be deducted from reported costs as recovery of expense.

(D) Depreciation schedule. This schedule shall support the depreciation expense reported on the cost report.

(E) Any other data deemed necessary by the agency for verification and rate determination shall also be submitted.

(c) Determination of maximum reimbursable medicaid rate per visit.

(1) Allowable facility costs. These are costs derived from reported expenses after making adjustments resulting from cost report review and application of the cost reimbursement principles discussed in K.A.R. 30-5-118b.

(2) Allocation of overhead costs. Total allowable administrative and facility costs shall be distributed to these cost centers: federally qualified health center costs, non-federally qualified health center costs, and non-reimbursable costs excluding bad debt. Accumulated direct cost in each cost center shall be used as the basis for the overhead cost allocation.

(3) Reimbursable rate. The sum of allowable pneumococcal and influenza vaccine cost, and other ambulatory services, cost after overhead allocation shall be divided by the total adjusted visits from paragraph (b)(2)(C) of this subsection. The resulting rate shall be added to the medicare maximum rate identified on the cost report.

(4) Average allowable cost per visit. The total allowable facility costs shall be divided by total adjusted visits.

(5) Maximum reimbursable medicaid rate. The lesser of the reimbursable rate from paragraph (c)(3) above and the average allowable cost per visit from paragraph (c)(4) above shall be the maximum reimbursable medicaid rate.

(d) Fiscal and statistical records and audits.

(1) Record keeping. Each provider shall maintain sufficient financial records and statistical data for proper determination of reasonable costs. Standardized definitions, and reporting practices

widely accepted among federally qualified health centers and related fields shall be followed, except to the extent that they may conflict with or be superseded by state or federal medicaid requirements.

(2) Audits and reviews.

(A) Each provider shall furnish any information to the agency that may be necessary to meet these criteria:

(i) Assure proper payment by the program pursuant to K.A.R. 30-50-118a and K.A.R. 30-5-118b;

(ii) substantiate claims for program payments; and

(iii) complete determination of program overpayment.

(B) Each provider shall permit the agency to examine any records and documents necessary to ascertain information for determination of the proper amount of program payments. These records shall include the following:

(i) Matters of the facility ownership, organization, and operation;

(ii) fiscal, statistical, medical, and other record-keeping systems;

(iii) federal and state income tax returns and all supporting documents;

(iv) documentation of asset acquisition, lease, sale, or other transaction;

(v) management arrangements;

(vi) matters pertaining to the cost of operation;

(vii) income received, by source and purpose; and

(viii) a statement of changes in financial position.

(C) Other records and documents shall be made available to the agency as requested.

(D) Records and documents shall be available in Kansas.

(E) Each provider shall furnish to the agency, upon request, copies of patient service charge schedules and changes thereto as they are put into effect.

(F) The agency shall suspend program payments if it is determined that a provider does not maintain adequate records for the determination of reasonable and adequate rates under the program, or if the provider fails to furnish requested records and documents to the agency.

(G) Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider of the agency's intent to suspend payment. The notice shall explain the ba-

sis for the agency's determination and identify the provider's record-keeping deficiencies.

(H) All provider records that support reported costs, charges, revenue, and patient statistics shall be subject to audits by the agency, the United States department of health and human services, and the United States general accounting office and shall be retained for five years after the date of filing the cost report with the agency.

(e) This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended July 1, 1994; amended July 1, 1997; amended Jan. 1, 1999.)

**30-5-118b.** (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective Jan. 1, 1999; revoked June 2, 2006.)

**30-5-119 to 30-5-149. Reserved.**

**30-5-150. Co-pay requirements for medikan program recipients.** (a) Medikan program recipients shall be obligated to the provider for co-payment amounts identical to the co-payment amounts for medicaid program recipients pursuant to K.A.R. 30-5-71. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended May 1, 1988.)

**30-5-151. Scope of hospital services for medikan program recipients.** Hospital services for medikan program recipients shall be limited to services provided for the following conditions:

- (a) Acute psychotic episodes;
- (b) traumatic injury;
- (c) burns; and
- (d) substance abuse acute detoxification. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective, T-84-8, March 29, 1983; amended, T-84-11, July 1, 1983; effective May 1, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked, T-30-12-28-89, Jan. 2, 1990; effective, T-30-2-28-90, Feb. 28, 1990; amended, T-30-6-10-91, July 1, 1991; amended Dec. 31, 1992; amended, T-30-2-15-93, Feb. 15, 1993; amended June 1, 1993.)

**30-5-152. Scope of rural health clinic**

**services for medikan program recipients.** The scope of rural health clinic services medikan program recipients shall be identical to the rural health clinic services pursuant to K.A.R. 30-5-82 covered for adult medicaid program recipients. (Authorized by and implementing K.S.A. 39-708c; effective, May 1, 1984; amended May 1, 1988.)

**30-5-153. Scope of physical therapist services.** (a) Physical therapist services shall be covered for medicaid/medikan beneficiaries when provided by a physical therapist who:

- (1) is certified by medicare; and
- (2) meets requirements listed in K.A.R. 100-35-1 through K.A.R. 100-35-7.

(b) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 29, 1995.)

**30-5-153a. Reimbursement for physical therapist services.** (a) Reasonable fees for customary charges shall be paid for physical therapist services except that no fee shall be paid in excess of the range maximum.

(b) The range of charges shall provide the base for the computation.

(c) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 29, 1995.)

**30-5-154. Scope of services by community mental health centers for medikan program recipients.** The scope of community mental health center services for medikan program recipients shall be identical to the community mental health center services pursuant to K.A.R. 30-5-86 covered for adult medicaid program recipients with the following exceptions: (a) Outpatient psychotherapy shall be limited to 24 hours per calendar year per medikan recipient when provided by a community mental health center, physician, psychologist, or any combination of these providers;

(b) psychological testing shall be prior authorized and limited to six hours in any three consecutive calendar years for medikan recipients; and

(c) targeted case management services and partial hospitalization services shall be limited to amounts specified by the secretary for medikan recipients. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1987; amended May 1, 1988.)

**30-5-155. Scope of Kan Be Healthy program services for medikan program recipients.** Kan Be Healthy program services shall not be covered for medikan program recipients. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended Jan. 2, 1989.)

**30-5-156. Scope of physician services for medikan program recipients.** The scope of physician services for medikan program recipients shall be identical to the physician services pursuant to K.A.R. 30-5-88 covered for medicaid program recipients with the exception that outpatient psychotherapy for medikan recipients shall be limited to 24 hours per calendar year per recipient when provided by a physician, psychologist, community mental health center, or any combination of these providers. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, March 29, 1983; amended, T-84-11, July 1, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988.)

**30-5-157. Scope of home health services for medikan program recipients.** The scope of home health services for medikan program recipients shall be identical to the home health services pursuant to K.A.R. 30-5-89 covered for adult medicaid program recipients. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1988.)

**30-5-158. Scope of pharmacy services for adult medikan program recipients.** Coverage shall be limited to prescription-only and over-the-counter drugs, supplies and devices that have been accepted for inclusion on any formulary listing for adult medikan program recipients which has been adopted and distributed, by the agency, to eligible providers of service. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.)

**30-5-159. Scope of dental services for medikan program recipients.** Dental services for medikan program recipients shall not be covered. The effective date of this regulation shall be December 31, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective, T-84-8, April 1, 1983; modified L. 1983, ch. 373, May 1, 1983; effective May 1, 1984; amended May 1,

1988; revoked, T-30-12-28-89, Jan. 2, 1990; effective, T-30-2-28-90, Feb. 28, 1990; amended, T-30-6-10-91, July 1, 1991; amended Dec. 31, 1992.)

**30-5-160. Scope of chiropractic services for medikan program recipients.** Chiropractic services for medikan program recipients shall not be covered. The effective date of this regulation shall be December 31, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective, T-84-8, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked, T-30-12-28-89, Jan. 2, 1990; effective, T-30-2-28-90, Feb. 28, 1990; amended, T-30-6-10-91, July 1, 1991; amended Dec. 31, 1992.)

**30-5-161. Scope of podiatric services for medikan program recipients.** Podiatric services for medikan program recipients shall not be covered. The effective date of this regulation shall be December 31, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective, T-84-8, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked, T-30-12-28-89, Jan. 2, 1990; effective, T-30-2-28-90, Feb. 28, 1990; amended, T-30-6-10-91, July 1, 1991; amended Dec. 31, 1992.)

**30-5-162. Scope of psychological services for medikan program recipients.** The scope of psychological services for adult medikan program recipients shall be identical to the psychological services pursuant to K.A.R. 30-5-104 covered for adult medicaid program recipients with the following exceptions:

(a) Outpatient psychotherapy shall be limited to 24 hours per calendar year per medikan recipient when provided by a psychologist, physician, community mental health center, or any combination of these providers;

(b) psychological testing and evaluation shall be limited to four hours in any three consecutive calendar years for medikan recipients; and

(c) targeted case management and partial hospitalization services shall be limited to amounts specified by the secretary of the department for medikan recipients. The effective date of this regulation shall be January 2, 1991. (Authorized by



and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152, Sec. 1; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked, T-30-12-28-89, Jan. 1, 1990; effective, T-30-2-28-90, Feb. 28, 1990; amended Jan. 7, 1991.)

**30-5-163. Scope of hearing services for medikan program recipients.** The scope of hearing services for medikan program recipients shall be identical to the hearing services pursuant to K.A.R. 30-5-105 covered for adult medicaid program recipients. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended May 1, 1988.)

**30-5-164. Scope of ambulance services for adult medikan program recipients.** Coverage shall be limited to emergency transportation to a facility where medical services are rendered. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.)

**30-5-165. Scope of non-ambulance medical transportation services for adult medikan program recipients.** Non-ambulance medical transportation services shall not be covered for adult medikan program recipients. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.)

**30-5-166. Scope of durable medical equipment, medical supplies, orthotic and prosthetic services for adult medikan program recipients.** Coverage for durable medical equipment and medical supplies shall be limited to services necessary to support life. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.)

**30-5-167. Scope of services in free-standing inpatient psychiatric facilities for medikan program recipients.** The scope of services in free-standing inpatient psychiatric facilities for medikan program recipients shall be identical to the free-standing inpatient psychiatric facility services pursuant to K.A.R. 30-5-109 for

adult medicaid program recipients. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1988.)

**30-5-168. Family planning services for medikan program recipients.** The scope of family planning services for medikan program recipients shall be identical to the family planning services pursuant to K.A.R. 30-5-88(b)(5) covered for adult medicaid program recipients. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1988; amended May 1, 1988.)

**30-5-169. Scope of partial hospitalization services for medikan program recipients.** (a) Partial hospitalization services shall be provided in a community mental health center or a facility affiliated with a community mental health center.

(b) Supportive partial hospitalization services shall be limited to a maximum of 720 hours per medikan recipient per calendar year.

(c) Crisis stabilization partial hospitalization services shall be limited to a maximum of 960 hours per medikan recipient per calendar year. The effective date of this regulation shall be December 31, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended July 1, 1989; revoked, T-30-12-28-89, Jan. 2, 1990; effective, T-30-2-28-90, Feb. 28, 1990; amended, T-30-6-10-91, July 1, 1991; amended Dec. 31, 1992.)

**30-5-170. Scope of services for ambulatory surgical centers for medikan program recipients.** The scope of ambulatory surgical center services for medikan program recipients shall be identical to the ambulatory surgical center services pursuant to K.A.R. 30-5-83 covered for adult medicaid program recipients. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1988.)

**30-5-171.** This rule and regulation shall expire on December 31, 1992. (Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended May 1, 1988; revoked, T-30-12-28-89, Jan. 2, 1990; effective, T-30-2-28-90, Feb. 28, 1990;

amended, T-30-6-10-91, July 1, 1991; revoked Dec. 31, 1992.)

**30-5-172. Scope of optometric services for adult medikan program recipients.** Optometric services shall not be covered for adult medikan program recipients. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.)

**30-5-173. This rule and regulation shall be revoked on and after March 1, 1995.** (Authorized by and implementing L. 1992, Chapter 322, K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective Jan. 4, 1993; revoked March 1, 1995.)

**30-5-173a. This rule and regulation shall be revoked on and after March 1, 1995.** (Authorized by and implementing L. 1992, Chapter 322, K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective Jan. 4, 1993; revoked March 1, 1995.)

**30-5-174. Delivery of managed care.** Counties shall be selected by the secretary pursuant to K.S.A. 1994 Supp. 39-7,112, as amended, to participate in managed care service delivery options. Subject to provider availability, any beneficiary may be required to choose a managed care option in order to access covered program services. (a) Managed care contractors shall be selected by the secretary from willing providers based upon the best professional judgment of the secretary or designees in the best interest of the agency.

(b) Before signing a contract to provide services, each provider of capitated managed care shall have the ability to meet contract requirements, including but not limited to:

- (1) financial solvency;
- (2) a panel of service providers who shall be:
  - (A) appropriately credentialed;
  - (B) in active practice;
  - (C) available to provide services to program enrollees; and
  - (D) culturally competent, which means a demonstrated ability to provide services which are sensitive to the needs of a diverse population including individuals of any income level, racial or ethnic background, language, handicapped condition or sexual preference;
- (3) an approved quality management process; and
- (4) other requirements determined by the sec-

retary. In order to participate as a managed care provider, each contractor shall abide by every provision of the contract. Penalties for failure to abide by contract provisions shall be imposed by the secretary or other appropriate actions, as enumerated in the contract provisions may be taken.

(c) Each capitated managed care contractor shall be reimbursed at a rate set by the secretary on an actuarially sound basis. Each provider of primary care case management shall be reimbursed for those medically necessary services which are covered on a fee for service basis, plus a case management fee as determined by the secretary.

(d) The effective date of this regulation shall be September 1, 1995. (Authorized by and implementing K.S.A. 39-708c; effective Sept. 1, 1995.)

**30-5-300. Definitions.** (a) The following words and terms for home- and community-based services (HCBS), when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

(1) "Accept medicare assignment" means that the provider will accept the medicare-allowed payment rate as payment in full for services provided to a consumer.

(2) "Activities of daily living (ADLs)" means the following:

- (A) Bathing;
- (B) dressing;
- (C) toileting;
- (D) transferring;
- (E) ambulating; and
- (F) eating.

(3) "Agency" means the Kansas department of social and rehabilitation services.

(4) "Area agency on aging" means the agency or organization within a planning and service area that has been designated by the secretary of the Kansas department on aging (KDOA) to develop, implement, and administer a plan for the delivery of a comprehensive and coordinated system of services to older persons in the planning and service area.

(5) "Assessment" means the face-to-face interview and evaluation of a home- and community-based services consumer by an authorized case manager, assessor, or independent living counselor to determine the consumer's care needs and support systems and to develop a service plan.

(6) "Case management services" means a comprehensive service comprised of a variety of spe-

cific tasks and activities designed to coordinate and integrate all other services required in the individual's plan of care.

(7) "Client obligation" means the monthly amount collected from an HCBS consumer by the service provider for the cost of a service.

(8) "Conflict of interest" means any relationship between two or more parties in which one party has the ability to influence another party to the transaction in a way that one or more of the transacting parties might fail to fully pursue the party's or parties' own separate interests. Related parties shall include parties related by family, business, or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations. Transactions or agreements that are illusory or a sham shall not be recognized.

(9) "Cost cap" means the average HCBS monthly service cost limit per consumer, including primary and acute care costs. The average HCBS monthly service cost limit shall be based on and compared to the average monthly cost that the consumer would incur in a nursing facility.

(10) "Cost-efficient" means that all of the formal and informal service systems available to meet individual needs are used before HCBS services are used.

(11) "Cost-effective" means that the cost of utilizing a service is recovered by the savings generated from avoiding the necessary utilization of a more expensive service.

(12) "Direct cost" means any cost that can be identified specifically with a particular cost objective.

(13) "Documentation" means maintenance of the HCBS consumer's case file, which shall include the following:

- (A) A current assessment or reassessment;
- (B) a plan of care;
- (C) a service plan;
- (D) an activity log; and
- (E) a financial eligibility communication form, including current client obligation information.

(14) "Effective date" means the date on which a program or service begins and on which a provider can be reimbursed for services.

(15) "Formal service" means any needed service as documented in the plan of care and funded by medicaid.

(16) "Frail elderly waiver" means a medicaid HCBS services waiver authorized by and through

the Kansas department on aging services in accordance with a federally approved waiver to the Kansas medicaid state plan for individuals age 65 and older who meet the medicaid long-term care threshold.

(17) "Home health aide service" means the direct care provided by a person with minimum training to consumers who are unable to care for themselves or who need assistance in accomplishing the activities of daily living. The home health aide service direct care provider shall be under the supervision of a registered nurse employed by a home health agency.

(18) "Home health agency" means a public or private agency or organization that provides, for a fee, one or more home health services at the residence of a consumer.

(19) "Housing options" means all home and residential environments in which individuals would be eligible to receive HCBS services.

(20) "Instrumental activities of daily living (IADLs)" means the following:

- (A) Meal preparation;
- (B) shopping;
- (C) medication monitoring and treatments;
- (D) laundry and housekeeping;
- (E) money management;
- (F) telephone use; and
- (G) transportation.

(21) "Independent living center" means a public or private agency or organization recognized by the agency whose primary function is to provide independent living services, including the following:

- (A) Independent living skills training;
- (B) advocacy;
- (C) peer counseling; and
- (D) information and referral.

(22) "Independent living counseling" means a service provided through the HCBS/physically disabled waiver that assesses need, negotiates care plans and service plans, and teaches independent living skills.

(23) "Indirect costs" means the administrative costs of long-term care (LTC) programs or their functional components, including the costs of supplying goods, services, and facilities to those programs or their functional components.

(24) "Ineligible provider" means a provider who is not enrolled in the medicaid/medikan program due to one or more of the reasons set forth in K.A.R. 30-5-60, or because the provider com-

mitted civil or criminal fraud in another state or another program.

(25) “Informal service” means any needed or desired service provided voluntarily to a consumer by one or more organizations, agencies, or families, at no cost to the medicaid program.

(26) “Level of care” means the functional needs of consumers, as determined through an assessment or reassessment, based on impairments in ADLs and IADLs.

(27) “Medicaid home- and community-based services (HCBS)” means services provided in accordance with a federally approved waiver to the Kansas medicaid state plan that are designed to prevent unnecessary utilization of services and to reduce health care-related costs. Any individual who has a primary diagnosis of mental illness and who is 21 years of age or older, but less than 65 years old, shall not be eligible.

(28) “Medicaid home- and community-based services for persons with mental retardation or other developmental disabilities (HCBS/MRDD)” means services provided in accordance with a federally approved waiver to the Kansas medicaid state plan. These services shall be designed as alternatives to services otherwise provided in intermediate care facilities for the mentally retarded (ICF/MR) for individuals who have mental retardation or other developmental disabilities.

(29) “Medicaid home- and community-based services for head-injured persons (HCBS/HI)” means medicaid services that meet these requirements:

(A) Are provided in accordance with a federally approved waiver to the Kansas medicaid state plan; and

(B) are designed as an alternative to services in brain injury rehabilitation facilities for individuals who meet these requirements:

(i) Have external, traumatic brain injuries; and  
(ii) are 18 years of age or older, but are less than 55 years of age. Any person receiving HCBS/HI waiver services may continue to receive these services after reaching age 55 if the Kansas medicaid HCBS program manager determines that the person is continuing to show progress in rehabilitation and increased independence.

(30) “Medicaid long-term care threshold” means the level-of-care criteria, as established by the agency and approved in the waiver to the medicaid state plan for HCBS, that are used to determine eligibility for medicaid long-term care programs.

(31) “Nursing facility (NF)” means a facility that meets these criteria:

(A) Meets state licensure standards;

(B) provides health-related care and services, prescribed by a physician; and

(C) provides residents with licensed nursing supervision 24 hours per day and seven days per week for ongoing observation, treatment, or care for long-term illness or injury.

(32) “Normal rhythms of the day” means the average time frame in which an individual without a physical disability typically completes clusters of ADL and IADL activities.

(33) “Organized health care delivery system” means a system, at least one component of which is organized for the purpose of delivering health care, that furnishes at least one service under a medicaid-covered waiver or the state plan.

(34) “Other developmental disability” means a condition or illness that meets these requirements:

(A) Is manifested before age 22;

(B) can reasonably be expected to continue indefinitely;

(C) results in substantial limitations in any three or more of the following areas of life functioning:

(i) Self-care;

(ii) understanding and the use of language;

(iii) learning and adapting;

(iv) mobility;

(v) self-direction in setting goals and undertaking activities to accomplish those goals;

(vi) living independently; or

(vii) economic self-sufficiency; and

(D) reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of extended or lifelong duration and are individually planned and coordinated.

(35) “Physically disabled (PD) waiver” means services provided in accordance with a federally approved waiver to the Kansas medicaid state plan for any individual who meets these requirements:

(A) Is 16 years of age or older. Consumers who turn 65 years of age while on the physically disabled waiver may remain on the waiver past age 65;

(B) is physically disabled according to social security disability standards;

(C) meets the medicaid LTC threshold; and

(D) requires assistance with normal rhythms of the day.

(36) “Plan of care (POC)” means a document



that states and prescribes the responsibilities of providers to ensure that the providers meet the health and safety needs of HCBS consumers. The document shall include the following information:

- (A) A statement identifying the need for care;
- (B) the estimated length of the service or program;
- (C) a description of the prescribed treatment, modalities, and methodology to be used;
- (D) a description of the expected results;
- (E) the name of the provider; and
- (F) the cost of the program or services.

(37) "Prior authorization" means that a service to be provided shall be reimbursed only when approval is given by the agency before the service is provided.

(38) "Program" means the Kansas medicaid/medikan program.

(39) "Provider enrollment" means the process through which the agency determines whether or not an applicant meets the requirements for persons or agencies to provide services to the medicaid program.

(40) "Reassessment" means an annual review and evaluation of an HCBS consumer's continued need for services.

(41) "Reimbursement rate" means the dollar value assigned by the secretary for a covered service.

(42) "Risk factor" means any condition that can increase an individual's functional impairment. The risk factor is used to determine needs for services, as appropriate for the individual's level of care.

(43) "Self-directed care" means an option under the HCBS program that allows an individual in need of care to live in a home environment and direct the attendant services that are essential to the maintenance of the individual's health and safety.

(44) "Service plan" means a document that describes specific tasks to be performed, based on the needs of the consumer. The description shall include the type of service, the frequency, and the provider.

(45) "Severe emotional disturbance waiver" means services provided in accordance with a federally approved waiver to the Kansas medicaid state plan for any individual who meets these requirements:

- (A) Is under 18 years of age or, if the individual is under 22 years of age, has continually received intensive community-based services for at least six

months before the date of the initial application for the waiver;

- (B) has received a DSM-IV diagnosis under axis 1 (clinical disorders);

(C) meets the criteria for a severe emotional disturbance;

(D) meets the following severity index criteria:

- (i) On a child behavior checklist (CBCL), a score of at least 70 on one subscale; and
- (ii) on a child and adolescent functional assessment scale (CAFAS), an overall score of 100, or at least 30 for each of two subscales; and

(E) according to clinical judgment, is in need of a state mental health hospital (SMHH).

(46) "Technology-assisted child" means a chronically ill or medically fragile child who meets these requirements:

- (A) Is 17 years of age or younger;
- (B) has an illness or disability that, in the absence of home care services, would require admission to or a prolonged stay in a hospital;

(C) needs both a medical device to compensate for the loss of a vital body function and substantial, continuous care by a nurse or other caretaker under the supervision of a nurse in order to avert death or further disability;

(D) is dependent at least part of each day on mechanical ventilators for survival; and

(E) requires prolonged intravenous administration of nutritional substances or drugs, or requires other medical devices to compensate for the loss of a vital body function.

(47) "Terminally ill" means the medical condition of an individual whose life expectancy is six months or less, as determined and documented by a physician.

(48) "Traumatic brain injury" means non-degenerative, structural brain damage resulting in residual deficits and disability that have been acquired by external physical injury.

(49) "Termination date" means the last day on which a program or service shall be reimbursed. For HCBS, this date shall not extend beyond the last date of medicaid eligibility.

(b) This regulation shall be effective on and after January 1, 2004. (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1997; amended July 1, 1997; amended, T-30-12-16-97, Jan. 1, 1998; amended April 1, 1998; amended July 1, 2002; amended Jan. 1, 2004.)

**30-5-301. Provider participation.** (a) Each provider shall meet the provider participa-

tion requirements specified in K.A.R. 30-5-59, including record keeping requirements, and the following additional requirements:

- (1) All assessment records;
- (2) All plan of care records; and
- (3) All case file documentation records.

(b) This regulation shall take effect on and after January 1, 1997. (Authorized and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Jan. 1, 1997.)

**30-5-302. Limitations for independent living counselors.** (a) An independent living center shall not use any consumer as an independent living counselor when that consumer receives services from the same independent living counseling agency.

(b) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Jan. 1, 1997.)

**30-5-303. Cost effectiveness.** (a) Except for "cost cap" approvals, each HCBS plan of care shall be cost-effective.

(b) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Jan. 1, 1997.)

**30-5-304. Cost efficient plans of care.** (a) Each HCBS plan of care shall be cost efficient and shall be provided in accordance with K.A.R. 30-5-70.

(b) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Jan. 1, 1997.)

**30-5-305. Assessment requirements.** (a) Qualified staff and assessment providers shall conduct an assessment prior to the implementation of any HCBS service.

(b) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Jan. 1, 1997.)

**30-5-306. Effective date for HCBS eligibility.** (a) The effective date of eligibility for

HCBS services shall not be before the effective date of medicaid eligibility.

(b) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Jan. 1, 1997.)

**30-5-307. Family reimbursement restriction.** (a) Neither an adult consumer's spouse nor a minor consumer's parents shall be paid to provide HCBS services to that consumer, unless all other possible options are exhausted and one of the following extraordinary criteria is met.

(1) Three HCBS provider agencies furnish written documentation that the consumer's residence is so remote or rural that HCBS services are otherwise completely unavailable.

(2) Two health care professionals, including the attending physician, furnish written documentation that the consumer's health, safety, or social well-being, would be jeopardized.

(3) The attending physician furnishes written documentation that, due to the advancement of chronic disease, the consumer's means of communication can be understood only by the spouse or by the parent of a minor child.

(4) Three HCBS providers furnish written documentation that delivery of HCBS services to the consumer poses serious health or safety issues for the provider, thereby rendering HCBS services otherwise unavailable.

(b) This regulation shall take effect on and after July 1, 1997. (Authorized by and implementing K.S.A. 1996 Supp. 39-708c; effective Jan. 1, 1997; amended July 1, 1997.)

**30-5-308. Nonsupplementation of HCBS services.** (a) An organization, agency, family, consumer, or other individual shall not be allowed to pay for services that are on the plan of care.

(b) A consumer may accept the following:

(1) Any available service that is provided free and voluntarily by one or more organizations, agencies, families, or other individuals, at no cost to the medicaid program; and

(2) any available, desired services in addition to those services on the plan of care that are purchased by the consumer or one or more organizations, agencies, families, or other individuals, at no cost to the medicaid program.

(c) This regulation shall be effective on and after December 31, 2002. (Authorized by and im-

plementing K.S.A. 39-708c; effective Jan. 1, 1997; amended Dec. 31, 2002.)

**30-5-309. Scope of and reimbursement for medicaid home- and community-based services (HCBS).** The scope of medicaid home- and community-based services shall consist of those services provided under the authority of the applicable federally approved waiver to the Kansas medicaid state plan. (a) Medicaid home- and community-based services shall be provided to medicaid-eligible consumers who are determined by individualized assessment to be qualified for the appropriate institutional level of care, and who elect to receive the services specified in individualized written plans of care designed to prevent living in an institution.

(b) Medicaid home- and community-based services shall consist of one or more of the services defined and federally approved in the medicaid home- and community-based waiver provided under a written plan of care.

(c) Medicaid home- and community-based services shall be provided in accordance with an individualized written plan of care approved in writing by the Kansas department of social and rehabilitation services for all waiver program services other than the frail elderly waiver program services, which shall be provided in accordance with an individualized written plan of care approved in writing by the Kansas department on aging. Each annual review and amendment of this plan shall be approved in the same fashion. This plan shall meet these requirements:

- (1) Be based on needs identified during the screening assessment;
  - (2) specify each service to be provided and why each service was selected, or how each service will address any specific need identified by the assessment;
  - (3) specify the frequency and limits of each provided service;
  - (4) specify any other required support services and the plan for obtaining them;
  - (5) be prepared in consultation with the consumer or the consumer's guardian, if one has been appointed;
  - (6) be approved in writing by the consumer or the consumer's guardian, as appropriate; and
  - (7) be reviewed at least annually and updated as necessary.
- (d) Medicaid home- and community-based services shall be subject to the individual and ag-

gregate expenditure limits applicable under the federally approved waiver.

(e) Medicaid home- and community-based services for a consumer shall be terminated when the Kansas department of social and rehabilitation services or the Kansas department on aging for the frail elderly program determines at least one of the following:

- (1) The consumer no longer meets the level of care criteria.
- (2) The consumer fails to cooperate with basic program requirements to the degree that the department's ability to deliver services is substantially impeded.
- (3) The written plan of care no longer meets the tests of cost-effectiveness, or a cost cap exception is not granted.
- (4) No provider of essential services is available in the consumer's home location.
- (5) The consumer enters a nursing facility for more than a planned brief stay.
- (6) The consumer becomes no longer eligible for medicaid.
- (7) The consumer requests termination of services.
- (8) The consumer dies.

(f) Reimbursement for medicaid home- and community-based services shall be based upon reasonable fees as related to customary charges, but no fee shall be paid in excess of the range maximum. The range of charges shall provide the basis for computations.

(g) This regulation shall take effect on and after July 1, 2000. (Authorized by and implementing K.S.A. 1999 Supp. 39-708c; effective July 1, 1997; amended July 1, 2000.)

**30-5-310. Scope and reimbursement for home- and community-based services for persons with a severe emotional disturbance.**

(a) The scope of home- and community-based services for persons with a severe emotional disturbance shall consist of those services provided under the authority of the applicable federally approved model waiver to the Kansas medicaid state plan.

(b) Home- and community-based services shall be provided in accordance with an individualized, written plan of care approved by the Kansas department of social and rehabilitation services.

(c) Before the development of any plan to provide services, the need for services shall be determined through an individualized assessment of

the prospective recipient made by a qualified assessor. A qualified assessor means a qualified mental health professional as defined in K.S.A. 59-2946, and amendments thereto.

(d) Services may include one or more of the following:

- (1) Respite care;
- (2) wraparound facilitation or community support;
- (3) independent living or skill building; and
- (4) parent support and training.

(e) Reimbursement for home- and community-based services for persons with a severe emotional disturbance shall be based upon reasonable fees as related to customary charges, except that no fee shall be paid in excess of the range maximum.

(f) This regulation shall take effect on and after April 1, 1998. (Authorized by and implementing K.S.A. 39-708c; effective, T-30-12-16-97, Jan. 1, 1998; effective April 1, 1998.)

#### **Article 6.—MEDICAL ASSISTANCE PROGRAM—CLIENTS' ELIGIBILITY FOR PARTICIPATION**

**30-6-1.** (Authorized by K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1976.)

**30-6-2 to 30-6-5.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-6.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-719b; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-7.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-8 and 30-6-9.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-10.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-6-11.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-12.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-6-13 to 30-6-15.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-16.** (Authorized by K.S.A. 1980 Supp. 38-827, 39-708c; effective, E-78-15, July 1, 1977; effective May 1, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-6-17 and 30-6-18.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; amended May 1, 1980; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

**30-6-19.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; amended, E-81-13, Aug. 8, 1979; amended May 1, 1980; revoked, E-81-19, July 16, 1980; revoked May 1, 1981.)

**30-6-20.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-6-21 and 30-6-22.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-23.** (Authorized by K.S.A. 39-719a, 39-720, K.S.A. 1980 Supp. 39-708c, 39-709, 39-719b; effective, E-78-15, July 1, 1977; effective May 1, 1978; revoked May 1, 1981.)

**30-6-24.** (Authorized by K.S.A. 1980 Supp. 39-708c, 39-709; effective, E-78-15, July 1, 1977; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-6-25 to 30-6-33. Reserved.**

**30-6-34. Program.** (a) The medical assistance program shall include applicants and recip-



ients classified as automatic eligibles and determined eligibles.

(b) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1984; amended Dec. 30, 1994; amended March 1, 1997.)

**30-6-35. Application process.** (a) Attention given to requests. All applications, inquiries, and requests for medical assistance shall be given prompt attention.

(b) Who may file. An application for medical assistance shall be made by each applicant, or by another person authorized to act on the applicant's behalf, except that an application on behalf of a person mandated to receive tuberculosis care or on behalf of a deceased person may be made by any responsible person.

(c) Applications.

(1) Each application for assistance shall be considered an application for any type of medical assistance. The applicant or person authorized to act on behalf of the applicant shall sign the application. If any person signs by mark, the names and addresses of two witnesses shall be required. An application on behalf of a deceased person shall be made within three months of the month of the person's death.

(2) When assistance is requested for a family member following approval of assistance for other family members, the month of application for that member shall be the month following the month of the request, if any necessary verification is received within 10 days of the request. If timely verification is not provided, the month of application shall be the month following the month verification is received.

(3) Applications may be submitted by either mail or fax.

(d) Time in which application is to be processed.

(1) Applications for medical assistance shall be approved or denied within 45 days of the agency's receipt of a signed application or within 90 days of the agency's receipt of a signed application for medical assistance that is dependent upon a finding of disability.

(2) The applicable time period may be extended if the application has been withdrawn or if the required determination of eligibility cannot

be made within the mandated time period due to the failure of the applicant or a collateral to provide necessary information.

(3) If the agency takes action to deny an application within either the 45-day or 90-day time period as indicated above and the applicant reapplies or provides required information within the 45-day or 90-day time period, the application shall be reactivated.

(e) This regulation shall take effect on and after November 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended May 1, 1984; amended May 1, 1988; amended July 1, 1989; amended, T-30-5-1-90, May 1, 1990; amended, T-30-7-2-90, Aug. 30, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended July 1, 1997; amended Nov. 1, 1998.)

**30-6-35w.** This regulation shall be revoked on and after March 1, 1997 (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-36. Redetermination of eligibility process.** (a) Purpose of redetermination. The purpose of the redetermination shall be to give the recipient an opportunity to bring to the attention of the agency the recipient's current situation and to give the agency an opportunity to review the factors of eligibility in order to determine the recipient's continuing eligibility for medical assistance.

(b) Acceptance of redetermination forms. Redetermination forms may be submitted in person, by mail, or by fax.

(c) Frequency of redetermination. A recipient's eligibility for medical assistance shall be redetermined as often as a need for review is indicated. Eligibility shall be reviewed at least once each 12 months.

(d) This regulation shall take effect on and after November 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended May 1, 1988; amended Nov. 1, 1998.)

**30-6-37. Reserved.**

**30-6-38.** (Authorized by and implementing K.S.A. 39-708c, as amended by 1990 HB 3085; effective May 1, 1981; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; revoked Aug. 11, 2006.)

**30-6-39. Responsibilities of applicants and recipients.** Each applicant or recipient shall:

(a) Supply, insofar as the applicant or recipient is able, information essential to the establishment of eligibility;

(b) give written permission for release of information regarding resources, when needed;

(c) report changes in circumstances within 10 calendar days of the change;

(d) meet their own medical needs insofar as they are capable; and

(e) cooperate with the agency in obtaining resources due the person or any other person for whom the individual is applying for or receiving medical assistance. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 39-719b; effective May 1, 1981; amended May 1, 1984; amended May 1, 1986.)

**30-6-40. Agency responsibility to applicants and recipients.** The agency shall: (a) on the request of an applicant or recipient, explain their rights and responsibilities;

(b) inform individuals of the following requirements placed upon the agency:

(1) the agency shall be required to make periodic redeterminations of eligibility;

(2) the agency shall be required to investigate and refer for legal action any fraudulent application for or receipt of assistance; and

(3) unless otherwise prohibited by law, the agency shall be required to disclose confidential information when the purpose of the disclosure is directly related to:

(A) the administration of the medical assistance program;

(B) an investigation, or criminal or civil proceeding being conducted in connection with the administration of the program; or,

(C) the reporting to the appropriate law enforcement officials the intention of an individual to commit a crime. Further, the agency shall be required to disclose confidential information concerning GA medical recipients if the purpose of such disclosure is directly related to:

(i) the administration of any other SRS program; or,

(ii) an investigation, or criminal or civil proceeding being conducted in connection with the administration of any other SRS program. (Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.)

**30-6-41. Assistance planning.** (a) Definitions.

(1) "Family group" means the applicant or recipient and all individuals living together in which there is a relationship of legal responsibility or a caretaker relationship.

(2) "Caretaker" means any of the following persons:

(A) The parent or parents, including the parent or parents of an unborn child; or

(B) the person who is assigned the primary responsibility for the care and control of the child as one of the following representatives:

(i) A guardian, conservator, or legal custodian; or

(ii) a relative as defined in paragraph (a)(4) of this regulation.

(3) "Eligible caretaker" means a caretaker who is considered in the plan with the child.

(4) "Relative" means any of the following individuals:

(A) Any blood relative who is within the fifth degree of kinship to the child, including any of these relatives:

(i) Parents;

(ii) siblings;

(iii) nephews;

(iv) nieces;

(v) aunts;

(vi) uncles; and

(vii) persons of preceding generations who may be denoted by prefixes of grand, great, great-great, or great-great-great;

(B) a stepfather, stepmother, stepbrother, or stepsister;

(C) a legally adoptive parent or parents or another relative or relatives of adoptive parents as noted in paragraphs (4) (A) and (B) above;

(D) a spouse of any person named in the above groups or a former spouse of any of those persons, if marriage is terminated by death or divorce.

(5) "Legally responsible relative" means the person who has the legal responsibility to provide support for the person in the plan.

(b) In independent living arrangements, the assistance plan for non-SSI children shall consist of all children in the family group and the legally responsible relatives for the children, if living together. A separate assistance plan shall be applicable to any child who is not living with a legally responsible relative, and the plan shall include the siblings of the child if in the family group. For all other persons, the assistance plan shall consist of

those members of the family group for whom assistance is requested and eligibility is determined. Eligibility for medical assistance shall not be denied for the reason that an application for medical assistance is made on behalf of a deceased person. Any individual excluded from the medical assistance plan shall not be eligible in a separate medical assistance plan, except that SSI recipients shall have a separate medical assistance plan.

(c) In institutional living arrangements, each person shall have a separate assistance plan, unless one of the following exceptions applies:

(1) The person's protected income level is being computed as if the person were maintaining independent living arrangements.

(2) The person's income and resources are considered available to both members of a couple as set forth in K.A.R. 30-6-106(f).

(3) A couple is residing in the same long-term care home, and only one spouse has income.

(d) Any person who is ineligible for medical assistance because of a penalty provision shall be excluded from that person's family group medical assistance plan.

(e) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 1997 Supp. 39-708c, K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended April 1, 1990; amended March 1, 1997; amended Nov. 1, 1998.)

**30-6-41w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-42 to 30-6-49. Reserved.**

**30-6-50. Determined eligibles; general eligibility factors.** The eligibility requirements set forth in K.A.R. 30-6-51 through K.A.R. 30-6-60 and K.A.R. 30-6-63 shall be eligibility factors applicable to determined eligibles, except as noted. The secretary may waive certain eligibility requirements and adopt additional eligibility

requirements for all, or designated areas, of the state for the purpose of utilizing special project funds or grants or for the purpose of conducting special demonstration or research projects. (Authorized by K.S.A. 1985 Supp. 39-708c; implementing K.S.A. 1985 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986.)

**30-6-50w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-51. Assistance eligibility, general.**

(a) Eligibility process. The determination of eligibility shall be based upon information provided by the applicant or recipient. If the information is unclear, incomplete, conflicting or questionable, a further review, including collateral contacts, shall be required.

(b) Eligible for medical assistance. Each applicant or recipient shall be eligible for medical assistance only when all applicable eligibility factors have been met. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c, 39-709; effective May 1, 1981; amended May 1, 1984.)

**30-6-52. Act on own behalf.** (a) Emancipated minor. "Emancipated minor" means a person who is age 16 or 17 and who is or has been married, or a person who is under the age of 18 and who has been given or acquired the rights of majority through court action.

(b) Ability to act on own behalf. Each applicant or recipient shall be legally capable of acting on his or her own behalf.

(1) Incapacitated persons shall not be eligible for medical assistance unless a caretaker, medical representative, representative payee for social security benefits, or a responsible adult with whom a child resides as a result of an approved social service plan applies for assistance on the person's behalf.

(2) Emancipated minors shall be eligible to receive medical assistance on their own behalf.

(3) Unemancipated minors shall not be deemed capable of acting on their own behalf and must reside with a caretaker, representative payee for social security benefits, or a responsible adult with whom the child resides as a result of an ap-

proved social service plan in order to be eligible for assistance, except when one of the following conditions exists.

(A) Either the parents of the minor are institutionalized or the minor has no parent who is living or whose whereabouts are known, and there is no other caretaker who is willing to assume parental control of the minor.

(B) The health and safety of the minor has or would be jeopardized by remaining in the household with the minor's parents or other caretakers.

(c) This regulation shall take effect on and after July 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c and 39-709; effective May 1, 1981; amended May 1, 1984; amended Jan. 4, 1993; amended Sept. 30, 1994; amended March 1, 1997; amended October 1, 1997; amended July 1, 1998.)

**30-6-52w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 1; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-53. Financial eligibility.** The following provisions shall apply to all determined eligible groups, except that subsections (c) and (d) of this regulation shall not apply to any pregnant woman or child who meets the provisions of K.A.R. 30-6-77, to any medicare beneficiary who meets the provisions of K.A.R. 30-6-86, or to any working disabled individual who meets the provisions of K.A.R. 30-6-87. (a) Definitions.

(1) "Eligibility base period" means the length of time used in the determination of financial eligibility. The length of the eligibility base period varies from one month to six months, based on the living arrangement of the persons in the assistance plan.

(2) "Spendedown" means the amount of applicable income that exceeds the protected income level in the eligibility base period and that is available to meet medical costs.

(3) "Patient liability" means the amount that the individual is required to pay towards the cost of care which the individual receives in an institutional arrangement. Patient liability shall be based on the amount of applicable income that exceeds the protected income level in the eligibility base period.

(b) The eligibility base period. For prior eligibility, the base period shall be the three months immediately preceding the month of application.

The application base period shall begin on the first day of the month in which the application was received. Subsequent eligibility base periods for recipients shall begin on the first day of the month following the expiration of the previous base period. Any reapplication received outside of a previously established eligibility base period shall be treated as a new application without regard to any previous eligibility base period. However, if the reapplication includes a request for prior eligibility, the base period of prior eligibility shall not extend into a previously established eligibility base period. The eligibility base period shall not exceed six months.

(c) Financial eligibility for persons in independent living and home- and community-based services arrangements.

(1) Total applicable income in the eligibility base period shall be compared to the protected income level for the base period. If the total applicable income is less than the protected income level and the individual owns property which has value within the allowable limits, the individual shall be financially eligible for medical assistance. If the total applicable income exceeds the protected income level and the individual owns property which has value within the allowable limits, the excess applicable income shall be the spenddown.

(2) Each applicant or recipient shall incur allowable medical expenses in an amount at least equal to the spenddown before becoming eligible for assistance. Medical expenses paid either voluntarily or involuntarily by third parties shall not be utilized to meet the spenddown, except for medical expenses paid by a public program of the state other than medicaid.

(3) A previously unconsidered increase in total applicable income during the current eligibility base period which results in an additional spenddown shall not alter the base period. The individual shall meet the additional spenddown during the eligibility base period before the individual becomes eligible or regains eligibility for medical assistance. Any payment made through the program within the current eligibility base period shall not be considered an overpayment if a previously eligible individual fails to meet the additional spenddown within the current eligibility base period.

(d) Financial eligibility for persons in institutional arrangements.

(1) Total applicable income in the eligibility



base period shall be compared to the protected income level for the base period. If the total applicable income is less than the protected income level and the individual owns property which has value within the allowable limits, the individual shall be financially eligible for medical assistance. If the total applicable income exceeds the protected income level and the individual owns property which has value within the allowable limits, the excess applicable income shall be the patient liability.

(2) Each applicant or recipient shall incur allowable medical expenses in an amount at least equal to the patient liability before becoming eligible for assistance. Medical expenses paid either voluntarily or involuntarily by third parties shall not be utilized to meet this liability, except for medical expenses paid by a public program of the state other than medicaid.

(3) Any increase in total applicable income during the current eligibility base period may result in financial ineligibility or in additional liability, but shall not alter the base period. Any payments made through the program within the current eligibility base period shall not be considered an overpayment if a previously eligible individual becomes ineligible because of an increase in total applicable income or fails to meet any additional liability within the current eligibility base period.

(e) Allowable expenses. The following expenses shall be applied to the spenddown or patient liability when the individual provides evidence that the individual has incurred or reasonably expects to incur the expenses within the appropriate eligibility base period, or has incurred and is still obligated for expenses outside of the appropriate eligibility base period which have not been previously applied to a spenddown or liability:

- (1) Co-pay requirements;
- (2) the pro rata portion of medical insurance premiums for the number of months covered in the eligibility base period regardless of the actual date of payment, past or future;
- (3) any medicare premiums which are not covered by the agency through the buy-in process. Premiums which are subject to buy-in shall not be allowable before completion of the buy-in process, even if the individual pays the premiums or the premiums are withheld;
- (4) if medically necessary and recognized under Kansas law, all expenses for medical services

incurred by the individual or a legally responsible family group member. Expenses for social services designated as medical services under the home- and community-based services (HCBS) program shall be allowable under this paragraph for persons in the HCBS program. Expenses for routine supplies as defined in K.A.R. 30-10-15a(b), and for institutional care where the individual does not meet nursing facility criteria through the level of care evaluation or reevaluation process as defined in K.A.R. 30-10-7, shall not be allowable under this paragraph; and

(5) the cost of necessary transportation by appropriate mode to obtain medical services set forth in paragraph (4) above.

(f) This regulation shall take effect on and after January 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Chapter 229, Section 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, and 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1987; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended Jan. 4, 1993; amended July 19, 1996; amended Jan. 1, 1997.)

**30-6-53w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Chapter 229, Section 104; effective Dec. 30, 1994; amended July 19, 1996; amended Jan. 1, 1997; revoked March 1, 1997.)

**30-6-54. Citizenship, alienage, and residence.** (a) Definition. "Resident" means any person who is living in the state voluntarily, with no intention of presently moving from the state, and who is not living in the state for a temporary purpose.

(1) Any child who is living in the state shall be considered a resident.

(2) Any person who is otherwise eligible for medicaid and who has entered the state with a job commitment or who is seeking employment shall be considered a resident.

(3) For institutionalized individuals, the following criteria shall be used to determine residency.

(A) Any person placed by a state agency in an

out-of-state institution shall be considered to retain residence in the state making the placement.

(B) Any person who is under age 21 or who became incapable of intent before age 21 shall be considered to have the same residence as the parent or legal guardian.

(C) Any person who became incapable of intent on or after age 21 shall remain a resident of the state in which the person is physically residing.

(D) Any other person shall be regarded as a resident of the state in which the person is living with the intention to remain there permanently or for an indefinite period.

(b) Citizenship and alienage. Each applicant or recipient shall be a citizen of the United States or shall be an alien who meets the conditions in either paragraph (1) or (2):

(1) The individual entered the United States before August 22, 1996 and meets one of these conditions:

(A) Is a refugee, including persons who are Cuban or Haitian entrants or admitted as Amerasian immigrants;

(B) is granted asylum;

(C) has deportation withheld;

(D) is a lawful, permanent resident;

(E) is an honorably discharged veteran or currently on active duty in the armed forces or is the spouse or unmarried dependent child of such an alien;

(F) is paroled into the United States for at least one year; or

(G) is granted conditional entry.

(2) The individual entered the United States on or after August 22, 1996 and meets one of these conditions:

(A) Is a refugee, including persons who are Cuban or Haitian entrants or admitted as Amerasian immigrants;

(B) is granted asylum;

(C) has deportation withheld;

(D) is an honorably discharged veteran or currently on active duty in the armed forces or is the spouse or unmarried dependent child of such an alien;

(E) is a lawful, permanent resident who has resided in the United States for at least five years;

(F) is paroled into the United States for at least one year and has resided in the United States for at least five years; or

(G) is granted conditional entry and has resided in the United States for at least five years.

An otherwise eligible alien who does not qualify

under the above provisions shall be eligible for emergency medical care.

(c) Residence. Each applicant or recipient shall be a resident of Kansas. The individual shall be living in the state and shall not be receiving assistance from another state. Temporary absence from the state with subsequent returns to the state, or intent to return when the purposes of the absence have been accomplished, shall not be considered to interrupt continuity of residence. Residence shall be considered to be retained until abandoned or established in another state. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c and 39-709; effective May 1, 1981; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended, T-30-2-20-97, March 1, 1997; amended May 16, 1997; amended June 26, 1998.)

**30-6-54w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-55. Cooperation.** (a) Establishment of eligibility. Each applicant, recipient, or ineligible caretaker shall cooperate with the agency in the establishment of eligibility. Failure to provide information necessary to determine eligibility shall render the family group ineligible for medical assistance as provided in K.A.R. 30-6-39.

(b) Potential resources. Each applicant or recipient shall cooperate with the agency in obtaining any resources due the applicant, recipient, or any other person for whom assistance is claimed. Failure to cooperate without good cause shall render the applicant or recipient ineligible for medical assistance.

(c) Social security number. Each applicant or recipient shall provide the agency with the applicant's or recipient's social security number. Failure to provide the number, or failure to apply for a number if the applicant or recipient has not previously been issued a number, shall render the applicant or recipient ineligible for assistance.

(d) Paternity and support. Each applicant or recipient shall cooperate with the agency in establishing the paternity of any child born out of wedlock for whom assistance is claimed, and in obtaining support payments for the applicant or recipient and for any child for whom assistance is claimed. Failure to cooperate shall render the applicant or recipient ineligible for assistance unless the individual demonstrates good cause for refusal.

ing to cooperate. Cooperation shall include the following actions:

(1) Appearing at the local child support enforcement office, as necessary, to provide information or documentation needed to establish the paternity of a child born out of wedlock, to identify and locate the absent parent, and to obtain support payments;

(2) appearing as a witness at court or at other proceedings as necessary to achieve the child support enforcement objectives;

(3) forwarding to the child support enforcement unit any support payments received from the absent parent that are covered by the support assignment; and

(4) providing information, or attesting to the lack of information, under penalty of perjury.

(e) Third party resources. Each applicant or recipient shall cooperate with the agency in identifying and providing information to assist the agency in pursuing any third party who may be liable to pay for medical services under the medical assistance program. Failure to cooperate without good cause shall render the applicant or recipient ineligible for medical assistance.

(f) Group health plan enrollment. Each applicant or recipient who is otherwise eligible shall cooperate with the agency in enrolling in a group health plan offered by the applicant's or recipient's employer if the agency has determined that such plan is cost effective. To be cost effective, the amount paid for premiums, co-insurance, deductibles, other cost-sharing obligations under the group health plan, and any additional administrative costs shall be less than the amount paid by the agency for an equivalent set of medicaid services. Failure to cooperate without good cause shall render the applicant or recipient ineligible for medical assistance.

(g) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, T-86-9, May 1, 1985; amended, T-86-19, July 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended Jan. 1, 1990; amended May 1, 1992; amended March 1, 1997.)

**30-6-55w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chap-

ter 265, Section 8; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-56. Transfer of assets.** (a) Definitions.

(1) "Transfer of assets" means any act, contract, or lease, which partially or totally passes the use, control, or ownership of assets of an applicant or recipient to another person or corporation. A disclaimer of an inheritance shall constitute a transfer of assets.

(2) For purposes of this regulation, "institutionalized individual" means an applicant or recipient who is residing in a:

(A) nursing facility;

(B) medical institution that is providing the individual a level of care equivalent to the care provided by a nursing facility; or

(C) home- and community-based services living arrangement.

(3) For purposes of this regulation, "assets" means all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or spouse is entitled to but does not receive because of action by:

(A) the individual or the individual's spouse;

(B) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(C) any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(b) Eligibility limitation. An institutionalized individual shall not be eligible for coverage of institutional or home- and community-based services if the individual or individual's spouse transferred assets for less than fair market value on or after:

(1) sixty months before the date the individual received or was otherwise eligible to receive these services and has applied for medical assistance in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual as specified in K.A.R. 30-6-109(c) (1) and (2)(B); or

(2) thirty-six months before the date the individual received or was otherwise eligible to receive these services and has applied for medical assistance in the case of all other transfers.

Multiple transfers that occur within a calendar

month shall be treated as a single transfer. The date of application for medical assistance referred to in subparagraphs (b)(1) and (b)(2) above shall be based on the most recent application for assistance.

(c) Exempted transfers. The following transfers shall not affect eligibility under the provisions of subsection (b):

(1) transfers of assets that have been approved by the agency. If the transfer is for fair market value and is a bona fide transaction, approval shall be granted by the agency;

(2) a transfer of assets executed pursuant to the division of assets provisions contained in K.A.R. 30-6-106;

(3) transfer of the institutionalized individual's home to:

(A) the spouse of the institutionalized individual;

(B) a child of the institutionalized individual who is under the age of 21 or who meets the blindness or disability criteria of K.A.R. 30-6-85;

(C) a sibling of the institutionalized individual who has an equity interest in such home and who was residing in the home for a period of at least one year immediately before the date the individual entered the institutional or home- and community-based services arrangement; or

(D) a child of the institutionalized individual other than the child described in item (3)(B) above, who was residing in the home for a period of at least two years immediately before the date the individual entered the institutional or home- and community-based services arrangement and who provided care to the institutionalized individual which permitted the individual to reside at home;

(4) a transfer of assets to:

(A) the institutionalized individual's spouse or to another for the sole benefit of the individual's spouse;

(B) the institutionalized individual's child who meets the blindness or disability criteria of K.A.R. 30-6-85 or to a trust established solely for the benefit of such child; or

(C) a trust established solely for the benefit of an individual under 65 years of age who meets the blindness or disability criteria of K.A.R. 30-6-85; and

(5) a transfer of assets from the institutionalized individual's spouse to another for the sole benefit of the spouse.

(d) Procedures. The procedures set forth be-

low shall be used in determining an institutionalized individual's eligibility for medical assistance under the above provisions.

(1) A record shall be assembled in chronological order for each transfer of assets.

(2) After securing the information listed above, the reason for the transfer shall be examined by the agency. In examining the reason for the transfer, a determination first shall be made as to whether fair market value was received. If the agency determines that fair market value was not received, it shall be presumed that the transfer was for the purpose of establishing eligibility, unless the person furnishes convincing evidence that the transfer was exclusively for some other purpose.

(3) The decision of the agency with respect to convincing evidence shall be governed by the following criteria.

(A) Any transfer of assets shall be considered in the light of the circumstances at the time the transfer was made.

(B) The weight given to an institutionalized individual's statement that the transfer was not connected with that person's application for medical assistance shall be in proportion to the length of the interval between the transfer and the application.

(C) The difference in the equity transferred and the consideration received shall be such that it would be evident to the ordinary individual that full value had not been received.

(D) An institutionalized individual shall not be penalized for removal of the individual's name from the title or restricting access to the assets if the individual can substantiate that the individual has no ownership interest in the assets. Factors to be documented and considered shall include the source and use of the assets. This provision shall not be applicable to jointly-owned assets between legally responsible persons.

(e) Period of ineligibility.

(1) If the agency determines that any institutionalized individual has transferred assets without the approval of the agency and for less than fair market value, the period of ineligibility shall be determined by the agency using the following formula.

(A) The uncompensated value of all resources and lump sum payments transferred on or after the time period specified in subparagraphs (b) (1) and (b) (2) shall be divided by the average monthly private pay rate of all nursing facilities in the state



to determine the number of months of ineligibility. Recurring income transferred on or after the time period specified in subparagraphs (b)(1) and (b)(2) shall continue to be considered as real and available income for purposes of determining patient liability.

(B) The period of ineligibility shall commence with the month in which the asset was transferred for applicants and no later than the second month following the month of transfer for recipients giving timely and adequate notice. In the case of the existence of a previously established period of ineligibility, the new period shall commence no earlier than the month following the month the previous established period ends.

(2) If the spouse of an institutionalized individual transfers an asset that results in a period of ineligibility and the spouse is later institutionalized and otherwise eligible for medical assistance, the remaining period of ineligibility shall be divided between the spouses. If the institutionalized individual is no longer subject to the established period of ineligibility, the remainder of that period shall be served by the spouse if he or she becomes institutionalized during the period.

(3) If there is evidence that a transfer was made for less than fair market value and later the asset is reconveyed to the individual, or if there is an adjustment in the transfer through which the individual receives fair market value, the loss of the asset no longer exists. The individual shall, if otherwise qualified, be eligible for medical assistance.

(4) The period of ineligibility shall be initially waived or subsequently suspended if it is determined that the action to waive or suspend is necessary to avoid undue hardship. Undue hardship may be granted if the individual verifies that he or she has exhausted all available legal remedies for reclaiming the property or receiving full compensation, that all otherwise available assets have been expended to meet living and medical expenses, and that the individual's health or life would be endangered if deprived of medical care. The effective date of this regulation shall be July 1, 1994. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended Sept. 26, 1988; amended July 1, 1989;

amended May 1, 1992; amended Jan. 4, 1993; amended May 3, 1993; amended Oct. 1, 1993; amended, T-30-11-16-93, Dec. 1, 1993; amended Jan. 3, 1994; amended July 1, 1994.)

**30-6-56w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-57.** This rule and regulation shall expire on October 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 29, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; revoked Oct. 1, 1989.)

**30-6-58.** This rule and regulation shall expire on October 1, 1989. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended, T-89-5, Jan. 21, 1988; amended Oct. 1, 1988; revoked Oct. 1, 1989.)

**30-6-59.** (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended March 1, 1997; revoked July 2, 1999.)

**30-6-59w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-60. Living in a public institution.** (a) Definition. "Public institution" means any institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(b) Living arrangement. Each applicant or recipient living in a public institution shall be ineligible for assistance unless that person is an otherwise eligible medicaid (title XIX) applicant or recipient who is:

(1) under the age of 21 or over the age of 65 and living in a state institution;

(2) blind or disabled, as defined by the social

security administration, and living in a state institution which has been approved as a title XIX intermediate care facility; or

(3) under the age of 21 (22 if receiving inpatient psychiatric care on the person's 21st birthday), or over the age of 65 and receiving inpatient care in a state institution which has been approved as a title XIX accredited psychiatric hospital.

Any individual who is physically residing in a jail or penitentiary or under the care, custody and control of a law enforcement official shall be ineligible unless the individual is on probation, parole or on bail. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c, 39-709; effective May 1, 1981; amended May 1, 1984.)

**30-6-60w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and 39-709, as amended by L. 1994, Chapter 265, Section 8; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-61 and 30-6-62. Reserved.**

**30-6-63. Assignment of rights to support or other third party payments.** Each applicant or recipient shall assign to the secretary any accrued, present, or future rights to support or other third party payments the individual may receive on his or her own behalf or on behalf of any other family member who is or would be in the assistance plan. The effective date of this regulation shall be October 1, 1989. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1988 Supp. 39-709; effective, T-86-19, July 1, 1985; effective May 1, 1986; amended Oct. 1, 1989.)

**30-6-64. Reserved.**

**30-6-65. Automatic eligibles.** (a) To be automatically eligible for medical assistance, a person shall meet the general eligibility requirements of K.A.R. 30-6-50 and K.A.R. 30-6-106(c)(2) and shall be within one of the following categories:

(1) A person who is legally entitled to and receiving SSI benefits and who is in compliance with the general eligibility requirements regarding residence;

(2) a person who is legally entitled to and receiving state supplemental payments from Kansas related to SSI;

(3) a person who is determined by the SSA to retain recipient status, although not currently receiving an SSI benefit;

(4) a person who is receiving public assistance, pursuant to article 4 of these regulations;

(5) a person who is not receiving public assistance for one of the following reasons:

(A) The person is eligible for less than \$10.00 of public assistance;

(B) the amount of recovery of an overpayment is greater than the budget deficit;

(C) the person is eligible using prospective budgeting, but ineligible due to retrospective accounting of income; or

(D) the person is eligible for TAF but does not wish to receive cash assistance;

(6) a person who is included in the assistance plan of a family that was receiving TAF, foster care assistance, or medical assistance based on the criteria of paragraph (a)(5)(D) in at least three of the six months immediately before the month in which the family became ineligible for TAF, foster care, or medical assistance based on the criteria of paragraph (a)(5)(D) as a result, in whole or in part, of collection or increased collection of support. Automatic eligibility for the medical assistance program shall continue for the four months immediately after the last month in which the family was eligible and legally entitled to receive TAF, foster care assistance, or medical assistance based on the criteria of paragraph (a)(5)(D) as long as the family remains ineligible for TAF, foster care, or medical assistance based on the criteria of paragraph (a)(5)(D) due to collection or increased collection of support;

(7) a person who is mandated to receive inpatient treatment for tuberculosis;

(8) a person who is not a public assistance recipient but is receiving maintenance payments from youth services;

(9) a child who is under 18 years of age and who meets the TAF income and resource requirements pursuant to article 4 of these regulations;

(10) a child born to a mother who is eligible for and receiving medicaid at the time of birth, for a period of up to one year, if both of the following requirements are met:

(A) The child shall remain eligible as long as the mother remains eligible for medicaid or would be eligible for medicaid if still pregnant; and

(B) the child shall remain in the same household with the mother;

(11) a child receiving foster care payments under title IV-E, regardless of the state making the payments;

(12) a child for whom an adoption assistance

agreement under title IV-E is in effect, even if assistance payments are not being made or the adoption assistance agreement was entered into with another state. Automatic eligibility shall begin when the child is placed for adoption, even if an interlocutory decree of adoption or a judicial decree of adoption has not been issued;

(13) a child for whom a non-title IV-E adoption assistance agreement is in effect between the state and the adoptive parents and who cannot be placed without medical assistance because the child has special needs for medical or rehabilitative care; or

(14) a person who is included in the assistance plan of a family that meets the following conditions for transitional medical services:

(A) The family has received TAF or medical assistance based on the criteria in paragraph (a)(5)(D) in three of the six months immediately before the first month of transitional medical services; and

(B) the family has lost eligibility for TAF or medical assistance based on the criteria in paragraph (a)(5)(D) due solely to increased earned income or hours of employment of the caretaker.

Assistance shall be initially provided for a period not to exceed six months if the individual submits ongoing status reports as may be required by the secretary.

Assistance shall be provided for an additional six-month period if the individual submits ongoing status reports as may be required by the secretary and if the individual's gross earned income, less the cost of childcare, does not exceed 185 percent of the federal poverty income guidelines.

(b) This regulation shall be effective on and after July 1, 2003. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended, T-85-34, Dec. 19, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-29, Nov. 1, 1986; amended, T-87-44, Jan. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-1-2-90, Jan. 2, 1990;

amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; amended, T-30-7-2-90, Aug. 1, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991; amended May 1, 1991; amended Jan. 2, 1992; amended July 1, 1996; amended March 1, 1997; amended July 1, 1998; amended July 1, 2003.)

**30-6-65w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c, 39-7,103 and L. 1994, Chapter 265, Section 9; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-66 to 30-6-69. Reserved.**

**30-6-70. Medicaid determined eligibles; eligibility factors specific to temporary assistance for families (TAF).** (a) A child shall meet the applicable general eligibility requirements of K.A.R. 30-6-50 and shall be under 18 years of age or age 18 and in secondary school or working towards the attainment of a GED to be eligible for the medical assistance program related to TAF.

(b) This regulation shall take effect on and after July 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended March 1, 1997; amended July 1, 1998.)

**30-6-70w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 7; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-71. Reserved.**

**30-6-72.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; revoked March 1, 1997.)

**30-6-72w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 7; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-73.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as

amended by 1992 SB 182, Sec. 5; effective May 1, 1981; amended, E-82-19, Oct. 29, 1981; amended May 1, 1982; amended, T-83-38, Nov. 23, 1982; amended May 1, 1983; amended May 1, 1986; amended July 1, 1989; amended Oct. 1, 1989; amended Feb. 1, 1990; amended Jan. 7, 1991; amended Oct. 1, 1992; revoked March 1, 1997.)

**30-6-74.** This rule and regulation shall expire on October 28, 1991. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1988 Supp. 39-709, as amended by L. 1989, Ch. 125, Sec. 1; effective May 1, 1981; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended April 1, 1990; revoked, T-30-8-9-91, Aug. 30, 1991; revoked Oct. 28, 1991.)

**30-6-75 and 30-6-76. Reserved.**

**30-6-77.** (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 1997 Supp. 39-708c and K.S.A. 1997 Supp. 39-709; effective, T-30-7-1-88, July 1, 1988; effective Sept. 26, 1988; amended July 1, 1989; amended, T-30-3-29-90, April 1, 1990; amended, T-30-7-2-90, Aug. 1, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended, T-30-12-28-90, Jan. 2, 1991; amended May 1, 1991; amended July 1, 1991; amended Sept. 30, 1994; amended Dec. 30, 1994; amended Oct. 1, 1997; amended Nov. 1, 1998; revoked June 30, 2006.)

**30-6-77w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-78. Medicaid (title XIX) determined eligibles—eligibility factors specific to aid to pregnant women (APW).** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 30-6-50 and the requirements set forth below.

(1) Each woman shall not be eligible for medical assistance under the provisions of K.A.R. 30-6-77.

(2) Each woman shall be medically determined to be pregnant.

(3) Financial eligibility shall be determined for

each month as if the child was born and living with the mother.

(b) Assistance under this provision shall continue for two calendar months following the month in which the pregnancy terminates. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1983; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended May 1, 1987; May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988.)

**30-6-78w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-79.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1988 Supp. 39-709, as amended by L. 1989, Ch. 125, Sec. 1; effective, T-85-26, Oct. 15, 1984; effective May 1, 1985; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended April 1, 1990; revoked March 1, 1997.)

**30-6-80. Medicaid (title XIX) determined eligibles—eligibility factors specific to children in foster care (FFP-FC).** (a) To be eligible for participation in the medical assistance program related to FFP-FC, the child shall:

(1) Meet the general eligibility requirements of K.A.R. 30-6-50;

(2) be under the age of 18, or a full time student in a secondary school, or in the equivalent level of vocational or technical training; and

(3) be living in a foster family home, a private nonprofit child care facility, a title XIX approved medical facility, a title XIX accredited psychiatric hospital, or an intermediate care facility. The home or child care facility shall be approved for placement.

(b) A written order of commitment shall be issued giving the secretary care, custody, and control of the child or a written order of commitment of an Indian child as defined by the federal Indian child welfare act, shall be issued by any court giving care, custody, and control to the four tribes social services child placing agency. (Authorized by and implementing K.S.A. 1982 Supp. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983.)

**30-6-81. Medicaid (title XIX) deter-**



**mined eligibles—eligibility factors specific to children living in title XIX accredited psychiatric hospitals or intermediate care facilities.**

To be eligible for participation in the medical assistance program under this provision, the child shall: (a) meet the general eligibility requirements of K.A.R. 30-6-50; and

(b) be under the age of twenty-one (21) or under twenty-two (22) if receiving inpatient psychiatric care on such person's twenty-first birthday and currently receiving inpatient care in a state institution which has been approved as a title XIX accredited psychiatric hospital or intermediate care facility. (Authorized by and implementing K.S.A. 1980 Supp. 39-708c, 39-709; effective May 1, 1981.)

**30-6-81w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-82. Technology-assisted child; determined eligibles.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 30-6-50 and the requirements set forth below to be eligible as a technology-assisted child.

(1) Each child shall be under the age of 18.

(2) Each child shall, if not for the provision of home- and community-based services, require the level of care provided in a hospital.

(3) Each child shall require substantial and ongoing care by a nurse and shall meet one of these requirements:

(A) Be dependent at least part of each day on mechanical ventilators for survival;

(B) require prolonged intravenous administration of nutritional substances or drugs; or

(C) need some other medical device to compensate for the loss of a vital body function.

(b) Eligibility shall be determined based on the financial eligibility standards and methodologies applicable to persons in home- and community-based services arrangements.

(c) The need for care and receipt of home- and community-based services under this provision shall be subject to approval by the division of medical programs.

(d) This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective, T-30-3-1-91, March 1,

1991; effective July 1, 1991; amended Oct. 1, 1997.)

**30-6-82w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-83 and 30-6-84. Reserved.**

**30-6-85. Medicaid (title XIX) determined eligibles—eligibility factors specific to the aged, blind, or disabled (AABD).** An applicant or recipient shall meet the applicable general eligibility requirements of K.A.R. 30-6-50 and the applicable specific eligibility requirements set forth below to be eligible for participation in the medical assistance program related to AABD.

(a) Age. An individual shall have attained the age of sixty-five (65) prior to or within the month for which eligibility is being determined.

(b) Blindness. An individual shall be blind as determined by the social security administration. The determination shall be made either by the social security administration or by disability determination services.

(c) Disability. An individual shall be disabled as determined by the social security administration. The determination shall be made either by the social security administration or by disability determination services. (Authorized by and implementing K.S.A. 1980 Supp. 39-708c, 39-709; effective May 1, 1981.)

**30-6-85w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-86. Poverty-level and low-income medicare beneficiaries; determined eligibles.** Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 30-6-50 and the specific eligibility requirements set forth in this regulation. (a) Age, blindness, or disability. Each individual shall meet the age, blindness, or disability requirements of K.A.R. 30-6-85.

(b) Medicare part A beneficiary. Each individual shall be entitled to medicare part A benefits.

(c) Other coverage. An individual who meets the poverty income guidelines of K.A.R. 30-6-103 (a)(10) shall not be seeking coverage under any other type of medical assistance.

(d) Financial eligibility. A percentage of the official federal poverty income guidelines as estab-

lished in K.A.R. 30-6-103 shall be used as the protected income level for the number of persons in the plan and any other persons whose income is considered. The total applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. However, the amount of an annual social security cost-of-living adjustment shall be disregarded in determining eligibility during the first quarter of the year for which the adjustment is provided. To be eligible, the total applicable income shall not exceed the poverty level established for the base period. The individual also shall not own nonexempt real or personal property with a resource value in excess of two times the allowable amount specified in K.A.R. 30-6-107 for the number of persons whose nonexempt resources are considered available to the individual.

(e) Assistance provided. Assistance under this regulation for individuals meeting the poverty income guidelines of K.A.R. 30-6-103(a)(7) shall be limited to the payment of allowable medicare premiums, deductibles, and coinsurance. Assistance for individuals meeting the poverty income guidelines of K.A.R. 30-6-103(a)(9) or (10) shall be limited to the payment of medicare part B premiums only.

(f) This regulation shall be effective on and after December 31, 2002. (Authorized by K.S.A. 39-708c and 38-2002; implementing K.S.A. 39-708c, 39-709, and 38-2002; effective Jan. 2, 1989; amended July 1, 1989; amended, T-30-12-28-90, Jan. 2, 1991; amended May 1, 1991; amended Jan. 4, 1993; amended July 2, 1999; amended Dec. 31, 2002.)

**30-6-86w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-87. Poverty level working disabled individuals; determined eligibles.** Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 30-6-50 and the specific eligibility requirements set forth below. (a) Blindness or disability. Each individual must meet the blindness or disability requirements of K.A.R. 30-6-85.

(b) Medicare part A beneficiary. Each individual must be entitled to medicare part A benefits under section 1818A of the social security act.

(c) Financial eligibility. A percentage of the of-

ficial federal poverty income guidelines as established in K.A.R. 30-6-103 shall be used as the protected income level for the number of persons in the plan and any other persons whose income is considered. Total applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. To be eligible under this provision, the total applicable income shall not exceed the poverty level established for the base period. The individual must also not own nonexempt real or personal property with a resource value in excess of two times the allowable amount specified in K.A.R. 30-6-107 for the number of persons whose nonexempt resources are considered available to the individual.

(d) Assistance provided. Assistance under this provision shall be limited to the payment of medicare part A premiums. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by 1990 HB 3085, K.S.A. 1989 Supp. 39-709; effective, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; effective Oct. 1, 1990.)

**30-6-87w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-88. Disabled individuals with earned income; determined eligibles.** (a) Each applicant and each recipient shall meet the general eligibility requirements of K.A.R. 30-6-50 and the specific eligibility requirements specified below.

(1) Each individual shall be at least 16 years old but less than 65 years of age.

(2) Each individual shall meet the blindness or disability requirements of K.A.R. 30-6-85.

(3) Each individual shall have earned income that is subject to federal insurance contributions act (FICA) taxes.

(b) Financial eligibility shall be based on a percentage of the official poverty income guidelines as established in K.A.R. 30-6-103, which shall be used as the protected income level for the number of persons in the plan and any other persons whose income is considered. Monthly applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. To be eligible under this regulation, the monthly applicable income shall not exceed the poverty level established for the base

period. If the individual also owns nonexempt real or personal property with a resource value in excess of \$15,000, which shall include any nonexempt resources of all family group members, that individual shall not be eligible under this regulation.

(c) For individuals whose monthly applicable income is greater than or equal to 100 percent of the federal poverty income guidelines, a premium shall be required, which shall not exceed seven and one-half percent of the monthly applicable income. Failure to pay the premium shall result in ineligibility.

(d) Each individual who is temporarily unemployed but intends to return to work shall continue to be eligible for coverage for up to six months if all other eligibility factors are met.

(e) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c, 39-709; effective July 1, 2002.)

**30-6-89. Individuals with breast or cervical cancer; determined eligibles.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 30-6-54 and the specific eligibility requirements set forth below.

(1) Each individual shall be screened for breast or cervical cancer under the breast and cervical cancer early detection program established under title XV of the public health service act by the centers for disease control and shall be found to need treatment for either breast or cervical cancer.

(2) Each individual shall be uninsured and not be otherwise eligible for medical assistance under any other category.

(3) Each individual shall be under age 65.

(b) Eligibility for coverage under this regulation shall end when the course of treatment is completed or if the individual no longer meets the eligibility requirements. There shall be no financial eligibility requirements.

(c) This regulation shall be effective on and after October 1, 2001. (Authorized by and implementing K.S.A. 39-708c; effective Oct. 1, 2001.)

**30-6-90.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; revoked, E-82-11, June 17, 1981; revoked May 1, 1982.)

**30-6-91. Youth formerly in foster care; determined eligibles.** (a) Each applicant or recipient shall meet the general eligibility require-

ments of K.A.R. 30-6-50 and the following conditions:

(1) In the month of the individual's eighteenth birthday, was in the custody of the secretary of social and rehabilitation services or the juvenile justice authority and was in an out-of-home placement, other than a public institution unless allowed in accordance with K.A.R. 30-6-60; and

(2) is at least 18 years old but under age 21 and was born on or after July 1, 1985.

(b) This regulation shall be effective on and after July 1, 2004. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c and K.S.A. 39-709; effective July 1, 2004.)

**30-6-92 to 30-6-93. Reserved.**

**30-6-94. Medical assistance (non-title XIX) determined eligibles; eligibility factors specific to persons living in nursing facilities for mental health (NF-MH).** (a) To be eligible for participation in the medical assistance program under this regulation, the individual shall meet the following conditions:

(1) Meet the general eligibility requirements of K.A.R. 30-6-50;

(2) be age 21 or older and under age 65;

(3) have a severe and persistent mental illness, as defined in K.A.R. 30-10-1a;

(4) be otherwise eligible for medicaid (title XIX) except for the individual's living arrangement; and

(5) not meet the provisions of K.A.R. 30-6-60(b) or K.A.R. 30-6-81(b).

(b) Eligibility shall be determined based on the financial eligibility standards and methodologies applicable to persons in institutional arrangements.

(c) Whether an individual has a severe and persistent mental illness shall be determined by a qualified mental health professional employed by a participating community mental health center, as defined in K.S.A. 59-2946 and amendments thereto.

(d) This regulation shall be effective on and after May 1, 2002. (Authorized by and implementing K.S.A. 39-708c, 39-709; effective Jan. 2, 1992; amended May 1, 2002.)

**30-6-94w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-95. Medical assistance (non-title**

**XIX) determined eligibles; eligibility factors specific to non-title XIX foster care (non-FFP-FC).** (a) To be eligible for participation in the medical assistance program related to non-FFP-FC, the child shall be:

(1) Under the age of eighteen (18) or a full time student in a secondary school or in the equivalent level of vocational or technical training;

(2) Ineligible for title XIX benefits; and

(3) In financial need as established in K.A.R. 30-6-53.

(b) A written order of commitment shall be issued giving the secretary care, custody, and control of the child.

(c) The living arrangement of the child shall be approved for placement. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982.)

**30-6-96 to 30-6-99. Reserved.**

**30-6-100.** (Authorized by and implementing K.S.A. 39-708c, 39-709; effective May 1, 1981; revoked, E-82-11, June 17, 1981; revoked May 1, 1982.)

**30-6-101 and 30-6-102. Reserved.**

**30-6-103. Determined eligibles; protected income levels.** (a) Independent living and home- and community-based services arrangements.

(1) The protected income level for any person in an independent living arrangement or in the home- and community-based services program shall be based on the total number of persons in the assistance plan and any other persons in the family group whose income is being considered.

(2) The protected income levels for independent living may also be used when an applicant or recipient meets either of these conditions:

(A) Enters a medicaid-approved facility, except that this provision shall not apply in situations in which only one spouse of a married couple enters an institutional living arrangement; or

(B) is absent from the home for medical care for a period not to exceed two months to allow for maintaining the applicant's or recipient's independent living arrangements.

(3) Except as specified in paragraphs (4), (5), (6), (7), and (8) below, the following table shall be used to determine the protected income level for persons in independent living.

**PERSONS IN INDEPENDENT LIVING  
(Per Month)**

<b>1</b>	<b>2</b>	<b>3</b>
\$475.00	\$475.00	\$480.00

The protected income level for additional persons shall be the sum of the basic standard for a like public assistance family plus the maximum state shelter standard.

(4) In determining eligibility for pregnant women and for infants under the provisions of K.A.R. 30-6-77(a) and (b), 150 percent of the official federal poverty income guidelines shall serve as the protected income level.

(5) In determining eligibility for other young children under the provisions of K.A.R. 30-6-77(c), 133 percent of the official federal poverty income guidelines shall serve as the protected income level.

(6) In determining eligibility for older children under the provisions of K.A.R. 30-6-77(d), 100 percent of the official federal poverty income guidelines shall serve as the protected income level.

(7) In determining eligibility for poverty-level medicare beneficiaries under the provisions of K.A.R. 30-6-86, 100 percent of the official federal poverty income guidelines shall serve as the protected income level.

(8) In determining eligibility for working disabled individuals under the provisions of K.A.R. 30-6-87, 200 percent of the official federal poverty income guidelines shall serve as the protected income level.

(9) In determining eligibility for low-income medicare beneficiaries under the provisions of K.A.R. 30-6-86, 120 percent of the official federal poverty income guidelines shall serve as the protected income level.

(10) In determining eligibility for low-income medicare beneficiaries under the provisions of K.A.R. 30-6-86, 120 to 135 percent of the official federal poverty income guidelines shall serve as the protected income level subject to available federal funding.

(11) In determining eligibility for disabled individuals with earned income under the provisions of K.A.R. 30-6-88, 300 percent of the official federal poverty income guidelines shall serve as the protected income level.

(b) Institutional living arrangements. For persons residing in institutional settings, the pro-



tected income level shall be \$30.00, except as specified in paragraph (a)(2).

(c) Home- and community-based services arrangements. For persons in the home- and community-based services program, the monthly protected income level shall be \$645.00. (Authorized by and implementing K.S.A. 39-708c and 38-2002; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended, T-84-36, Dec. 21, 1983; amended May 1, 1984; amended, T-85-34, Dec. 19, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended, T-86-42, Jan. 1, 1986; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-88-2, Feb. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-3-29-90, April 1, 1990; revoked, T-30-7-2-90, July 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991; amended, T-30-12-28-90, Jan. 2, 1991; amended May 1, 1991; amended July 1, 1991; amended Jan. 2, 1992; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; amended Jan. 4, 1993; amended Jan. 3, 1994; amended Dec. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended July 1, 1998; amended July 2, 1999; amended July 1, 2002; amended Dec. 31, 2002; amended, T-30-1-2-03, Feb. 1, 2003; amended April 18, 2003.)

**30-6-103w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Dec. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; revoked March 1, 1997.)

**30-6-104. Reserved.**

**30-6-105.** This rule and regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1986; revoked March 1, 1997.)

**30-6-105w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-106. General requirements for consideration of resources, including real property, personal property, and income.** (a) For purposes of determining eligibility for assistance, legal title shall determine ownership. In the absence of legal title, possession shall determine ownership.

(b) Resources, to be real, shall be of a nature that the value can be defined and measured. The objective measures set forth in paragraphs (1) and (2) of this subsection shall establish the resources' value.

(1) Real property. The value of real property shall be initially determined by the latest uniform statewide appraisal value of the property, which shall be adjusted to reflect current market value. If the property has not been appraised or if the market value as determined above is not satisfactory to the applicant, recipient, or agency, an estimate or appraisal of the value of the property shall be obtained from a disinterested real estate broker. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(2) Personal property. The market value of personal property shall be initially determined using a reputable trade publication. If a publication is not available or if there is a difference of opinion regarding the value of the property between the agency and the individual, an estimate from a reputable dealer shall be used. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(c) (1) Resources shall be considered available both when the resources are actually available and when the applicant or recipient has the legal ability to make the resources available. A resource shall be considered unavailable when there is a legal impediment that precludes the disposal of the resource. The applicant or recipient shall pursue reasonable steps to overcome the legal impediment unless it is determined that the cost of pursuing legal action would exceed the resource value of the property or that it is unlikely the applicant or recipient would succeed in the legal action.

(2) For SSI, real property shall be considered

unavailable if the property cannot be sold for one of the following reasons:

(A) The property is jointly owned, and its sale would cause undue hardship because of the loss of housing for the other owner or owners.

(B) The owner's reasonable efforts to sell the property have been unsuccessful.

(d) The resource value of property shall be that of the applicant's or recipient's equity in the property. Unless otherwise established, the proportionate share of jointly owned real property and the full value of jointly owned personal property shall be considered available to the applicant or recipient. Resources held jointly with a nonlegally responsible person may be excluded from consideration if the applicant or recipient demonstrates that all of the following conditions exist:

(1) The applicant or recipient has no ownership interest in the resource.

(2) The applicant or recipient has not contributed to the resource.

(3) Any access to the resource by the applicant or recipient is limited to those duties performed while the applicant or recipient is acting as an agent for the other person.

(e) Nonexempt resources of all persons in the assistance plan shall be considered in determining eligibility.

(f) (1) The combined resources of husband and wife, if they are living together, shall be considered in determining the eligibility of either or both for the medical assistance program, unless otherwise prohibited by law.

(2) A husband and wife shall be considered to be living together if they are regularly residing in the same household. Temporary absences of either the husband or the wife for education, training, working, securing medical treatment, or visiting shall not interrupt the period of time during which the couple is considered to be living together.

(3) A husband and wife shall not be considered to be living together if they are physically separated and not maintaining a common life, or if one or both enter into an institutional living arrangement, including either a medicaid-approved or non-approved medical facility or a home- and community-based services care arrangement.

(A) If only one spouse enters an institutional living arrangement, the provisions of subsection (l) shall apply.

(B) If both spouses enter an institutional living arrangement, the combined resources of the hus-

band and wife shall be considered available to both for the month in which the institutional arrangement begins.

(g) The resources of an ineligible parent shall be considered in determining the eligibility of a minor child for the medical assistance program if the parent and child are living together. However, these resources shall not be considered for children in an institutional or home- and community-based services arrangement beginning with the month following the month the arrangement begins.

(h) Despite subsections (e), (f), and (g), the resources of an SSI beneficiary shall not be considered in the determination of eligibility for medical assistance of any other person.

(i) The conversion of real and personal property from one form of resource to another shall not be considered to be income to the applicant or recipient, except for the proceeds from a contract for the sale of property.

(j) Income shall not be considered to be both income and property in the same month.

(k) Despite subsection (e), the resources of a child whose needs are met through foster care payments shall not be considered in determining eligibility.

(l) If one spouse enters an institutional living arrangement, the other spouse remains in the community, and an application for medical assistance is made on behalf of the institutionalized spouse, the following provisions shall apply:

(1) The separate income of each spouse shall not be considered to be available to the other beginning in the month the institutional arrangement begins. Unless it is otherwise established that less or more than this value is available,  $\frac{1}{2}$  of the income that is paid in the names of both spouses shall be considered available to each. Income that is paid in the name of either spouse, or in the name of both spouses and the name of another person or persons, shall be considered available to each spouse in proportion to the spouse's interest, unless it is otherwise established that less or more than this value is available.

(2) (A) A monthly income allowance for the community spouse shall be deducted from the income of the institutionalized spouse in determining the amount of patient liability for persons in institutional living arrangements or in a spend-down status for persons in home- and community-based services arrangements.

(B) The income allowance for the community

spouse, when added to the income already available to that spouse, shall not exceed 150 percent of the official federal poverty income guideline for two persons plus the amount of any excess shelter allowance. "Excess shelter allowance" means the amount by which the community spouse's expenses for rent or mortgage payments, taxes and insurance for the community spouse's principal residence, plus the food stamp standard utility allowance, exceeds 30 percent of 150 percent of the federal poverty income guideline amount referred to in this paragraph.

(C) The maximum monthly income allowance that can be provided under this subsection shall be \$1,500.00. The \$1,500.00 limitation shall be increased at the beginning of each calendar year by the same percentage as the percentage increase in the consumer price index for all urban consumers between September, 1988 and the September before the calendar year involved.

(D) If a greater income allowance is provided under a court order of support or through the fair hearing process, that amount shall be used in place of the limits specified in paragraph (1)(2)(C).

(3) A monthly income allowance for each dependent family member shall be deducted from the income of the institutionalized spouse in determining the amount of patient liability for persons in institutional living arrangements or in a spenddown status for persons in home- and community-based services arrangements.

(A) "Dependent family member" means a person who is a minor or dependent child, dependent parent, or dependent sibling of either spouse and who lives with the community spouse.

(B) The allowance for each member shall be equal to  $\frac{1}{3}$  of 150 percent of the official federal poverty income guideline for two persons.

(C) An allowance for a dependent family member shall not be provided if the family member's gross income is in excess of 150 percent of the federal poverty income guideline for two persons.

(4) If the spouse is institutionalized on or after September 30, 1989, the real and personal property of both spouses shall be considered in determining the eligibility of the institutionalized spouse, based on the amount of property in excess of the community spouse property allowance as set forth in paragraph (1) (6), whether or not this allowance will be made.

(A) If the excess property is within the allowable resource standards of K.A.R. 30-6-107, the institutionalized spouse shall be eligible.

(B) In the month following the first month of eligibility for the institutionalized spouse, only the property of the institutionalized spouse shall be considered available in determining continuing eligibility, except for property to be transferred in accordance with paragraph (1)(6).

(5) If the spouse was institutionalized before September 30, 1989, the real and personal property of each spouse shall be considered available to the other in the month in which the institutional arrangement began. Thereafter, the property of each spouse shall not be considered available to the other.

(6) The institutionalized spouse may make available to the community spouse a property allowance that, when added to the property already available to the community spouse, would be equal to  $\frac{1}{2}$  of the total value of the property owned by both spouses at the beginning of the first period of continuous institutionalization beginning on or after September 30, 1989.

(A) This property allowance shall not exceed \$60,000.00, and shall be no less than \$12,000.00. Both the \$12,000.00 and \$60,000.00 standards shall be increased at the beginning of each calendar year by the same percentage as the percentage increase in the consumer price index for all urban consumers between September, 1988 and the September before the calendar year involved.

(B) If a greater property allowance is provided under a court order of support or through the fair hearing process, that amount shall be used in place of the limits specified in paragraph (1)(6)(A). If a greater property allowance is required to increase the community spouse's income to the amount allowed under paragraphs (1)(2)(B) and (C) of this regulation, a fair hearing officer shall take into account the income-generating value of the current property allowance as well as the additional property allowance requested. The property provided shall be invested so that income is maximized, including through a single premium annuity, and based on the salable or market value of the property.

(7) The amount of property received by the community spouse as a result of the property allowance determined in paragraph (1)(6) shall not be considered in determining the eligibility of the institutionalized spouse, except as provided in paragraph (1)(4). If the institutionalized spouse will be eligible based upon transferring sufficient property to the community spouse to equal the

amount of the property allowance, the institutionalized spouse shall be given up to 90 days from the date of application to transfer the property. Additional time may be allowed for good cause. Pending disposition of the property, the institutionalized spouse shall be eligible during this time period if all other eligibility factors are met.

(m) The resources of an alien sponsor and the sponsor's spouse shall be considered in determining eligibility for the alien. (Authorized by and implementing K.S.A. 39-708c, 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Jan. 1, 1988; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended April 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; revoked, T-30-11-29-90, Jan. 2, 1991; amended Jan. 7, 1991; amended, T-30-12-28-90, Jan. 2, 1991; amended, T-30-3-1-91, March 1, 1991; amended May 1, 1991; amended July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended Jan. 2, 1992; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; amended Jan. 4, 1993; amended Oct. 1, 1993; amended, T-30-11-16-93, Dec. 1, 1993; amended Jan. 3, 1994; amended Feb. 6, 1995; amended Dec. 29, 1995; amended March 1, 1997; amended Oct. 1, 1997; amended March 7, 2003.)

**30-6-106w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708; effective Dec. 30, 1994; amended February 6, 1995; amended Dec. 29, 1995; revoked March 1, 1997.)

**30-6-107. Property exemption.** Ownership of otherwise nonexempt real or personal property shall not affect eligibility if the aggregate resource value is not in excess of \$2,000.00 for one person or \$3,000.00 for two or more persons whose nonexempt resources are considered available to a person in the assistance plan. (a) For non-SSI, ownership of property with a resource value in excess of the amounts specified above shall render the assistance family group ineligible for medical assistance, except for pregnant

women and children who meet the provisions of K.A.R. 30-6-77. However, if there is ineligibility due to excess real property, assistance shall be provided for a period of up to nine months if the applicant or recipient is making a bona fide and documented effort to dispose of the property.

(b) For SSI, ownership of property with a resource value in excess of the amounts specified above shall render the assistance family group ineligible for medical assistance except for the following:

(1) For medicare beneficiaries who meet the provisions of K.A.R. 30-6-86 and working disabled individuals who meet the provisions of K.A.R. 30-6-87, the resource value shall be in excess of two times the amounts specified above before the assistance family group is rendered ineligible.

(2) For disabled individuals with earned income who meet the provisions of K.A.R. 30-6-88, the resource value shall be in excess of \$15,000 before the assistance family group is rendered ineligible.

If the applicant or recipient is making a bona fide and documented effort to dispose of the excess property at a reasonable market value, assistance shall be provided not to exceed nine months. This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-33, Dec. 19, 1984; amended, T-85-34, Dec. 19, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-43, Jan. 1, 1987; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended July 1, 1991; amended Dec. 30, 1994; amended July 1, 2002.)

**30-6-107w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-108. Real property.** (a) Definitions.

(1) "Home" means the house or shelter in which the applicant or recipient is living or from which the applicant or recipient is temporarily absent, as well as the tract of land and contiguous



tracts of land upon which the house and other improvements essential to the use or enjoyment of the home are located. Tracts of land shall be considered to be contiguous if lying side by side, except for streets, alleys, or other easements. Pieces of property that touch only at the corners shall not be considered to be contiguous.

(2) For non-SSI, "other real property" means any of the following types of property:

(A) Real property other than a home;

(B) a home from which an applicant or recipient has been temporarily absent for at least 12 months; or

(C) a home to which an applicant or recipient will be unable to return.

(3) For SSI, "other real property" means any of the following types of property:

(A) Real property other than a home; or

(B) a home from which an applicant or recipient has been absent and does not intend to return.

(4) For persons entering institutional living situations, the home shall become other real property after three months unless the absence is determined to be temporary, or a spouse, dependent child, or another dependent relative remains in the home.

(b) Treatment of real property. The equity value of nonexempt real property shall be considered as a resource.

(c) Exempted real property. The equity value of the following classifications of real property shall be exempt:

(1) The home;

(2) other real property that is essential for employment or self-employment;

(3) for non-SSI, other real property that is producing income consistent with its fair market value;

(4) for SSI, income-producing other real property that is used in an individual's trade or business; and

(5) for SSI, the equity value of non-business income-producing other real property if both of the following conditions are met:

(A) The equity value of the income-producing other real property plus the equity value of non-business income-producing personal property does not exceed \$6,000.00; and

(B) a net annual return of at least six percent of the total equity is produced.

(d) This regulation shall be effective on and after July 1, 2003. (Authorized by K.S.A. 39-708c;

implementing K.S.A. 39-708c and K.S.A. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 29, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended, T-30-5-1-90, May 1, 1990; amended, T-30-7-2-90, Aug. 30, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended March 1, 1997; amended July 1, 2003.)

**30-6-109. Personal property.** (a) Definitions.

(1) "Personal property" means all property, excluding real property.

(2) "Cash assets" means the following resources:

(A) Money;

(B) investments;

(C) cash surrender or loan values of life insurance policies;

(D) trust funds; and

(E) similar items on which a determinate amount of money can be realized.

(3) "Other personal property" means the following:

(A) Personal effects;

(B) household equipment and furnishings;

(C) home produce;

(D) livestock;

(E) equipment;

(F) vehicles;

(G) inventory;

(H) contracts from the sale of property; and

(I) similar items on which a determinate amount of money can be realized.

(b) Treatment of personal property. Personal property, unless exempted, shall be considered a resource. Trust funds shall be subject to subsection (c).

(c) Treatment of trust funds. For purposes of determining an individual's eligibility for assistance or the amount of assistance, the following requirements shall apply to trust funds. The term "trust" shall include any legal instrument or device that is similar to a trust, including an annuity. The term "assets" shall be defined as specified in K.A.R. 30-6-56(a)(3).

(1) In the case of a revocable trust, the value of the trust shall be considered a resource available to the individual. Payments from the trust to

or for the benefit of the individual shall be considered to be income. All other payments made from the trust shall be considered under the property transfer provisions of K.A.R. 30-6-56.

(2) Irrevocable trusts.

(A) If there are any circumstances under which payment from an irrevocable trust could be made to the individual or for the benefit of the individual, the portion of the trust from which payment could be made shall be considered as a resource available to the individual. Payments made from the trust to the individual or for the benefit of the individual shall be considered income. All other payments made from the trust shall be considered under the property transfer provisions of K.A.R. 30-6-56.

(B) Each portion of the trust from which no payment could be made to the individual under any circumstances shall be considered from the date of establishment of the trust, or if later, the date on which payment to the individual was restricted or foreclosed, under the property transfer provisions of K.A.R. 30-6-56.

(3) An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the trust and if any of the following individuals established the trust, other than by will:

(A) The individual or the individual's spouse;

(B) any person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(C) any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(4) If the corpus of the trust includes assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(5) The provisions of this subsection shall apply without regard to the purposes for which the trust was established, whether or not the trustees have or exercise any discretion under the trust, any restrictions on when or whether distributions can be made from the trust, or any restrictions on the use of distributions from the trust.

(6)(A) The provisions of this subsection shall not apply to a trust that contains the assets of an individual under age 65 who meets the blindness or disability criteria of K.A.R. 30-6-85 and that is established for the benefit of the individual by a

parent, grandparent, or legal guardian of the individual, or a court. The state shall receive all amounts remaining in the trust upon the death of the individual, up to an amount equal to the total medical assistance paid on behalf of the individual.

(B) The provisions of this subsection shall not apply to a trust containing the assets of an individual who meets the blindness or disability criteria of K.A.R. 30-6-85 if the trust meets all the following criteria:

(i) The trust is established by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust.

(iii) Accounts in the trust are established solely for the benefit of individuals who meet the blindness or disability criteria of K.A.R. 30-6-85.

(iv) Each account in the trust is established by that individual; the parent, grandparent, or legal guardian of the individual; or a court. The state shall receive all amounts remaining in the individual's account upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

(7) The provisions of this subsection shall be waived if it is determined that a waiver is necessary to avoid undue hardship on the individual. A finding of undue hardship may be granted if the individual verifies that all of the following conditions have been met:

(A) The individual has exhausted all legal remedies for gaining access to the principal or income of the trust.

(B) All otherwise available assets have been expended to meet living and medical expenses.

(C) The individual's health or life would be endangered if the individual were deprived of medical care.

(d) Exempted personal property. The resource value of the following classifications of personal property shall be exempt:

(1) Personal effects;

(2) household equipment and furnishings in use or only temporarily not in use;

(3) tools in use and necessary for the maintenance of a house or a garden;

(4) the stock and inventory of any self-employed person that are reasonable and necessary in the production of goods and services;

(5) items for home consumption, which shall consist of the following:

(A) Produce from a small garden consumed

from day to day and any excess that can be canned or stored; and

(B) a small flock of fowl or livestock that is used to meet the food requirements of the family;

(6) cash assets that are traceable to income exempted as income and as a cash asset;

(7) any contract for the sale of property, if the proceeds from the contract are considered as income;

(8) one vehicle for each assistance family. Additional vehicles may be exempt if used over 50 percent of the time for employment or self-employment, if used as the family's home, if needed for medical treatment of a specific medical problem, or if specially equipped for use by a handicapped person;

(9) individual development accounts funded under public law 105-285, authorized by section 404(h) of title VI of the social security act, or established by the state;

(10) individual training accounts administered by the Kansas department of human resources under the workforce investment act for purposes of job training or other employment readiness services. Deposits shall not exceed 50 percent of earned income in any calendar year and shall be maintained in a separate account;

(11) for non-SSI income-producing personal property, other than cash assets, that is essential for employment or self-employment or producing income consistent with its fair market value. Income-producing property may include any of the following items:

- (A) Tools;
- (B) equipment;
- (C) machinery; or
- (D) livestock;

(12) for non-SSI, proceeds from the sale of a home if the proceeds are conserved for the purchase of a new home and the funds so conserved are expended or committed to be expended in the month received or in the following month;

(13) for non-SSI, burial plots and funeral agreements that meet conditions established by the secretary of health and human services and approved by the secretary of social and rehabilitation services;

(14) for non-SSI, escrow accounts established for families participating in the family self-sufficiency program through the department of housing and urban development. Interest earned on the accounts shall also be exempted as income;

(15) for non-SSI, the cash value of any life insurance policy;

(16) for SSI, insurance not exceeding \$1,500.00 face value that is owned by any applicant or recipient. The face value shall not include and shall not be increased by accumulated dividends, but shall be decreased by any outstanding policy loan. If the total face value of insurance policies owned by any one individual exceeds \$1,500.00, the total cash surrender value of those policies shall be a nonexempt resource;

(17) for SSI, any personal property of a blind or disabled person that is covered by an approved plan of self-support;

(18) for SSI, burial plots that meet conditions established by the secretary of health and human services for the SSI program;

(19) for SSI, any burial contract that meets conditions established by the secretary of health and human services for the SSI program and approved by the secretary of social and rehabilitation services;

(20) for SSI, proceeds from the sale of a home if the proceeds are conserved for the purchase of a new home and the funds so conserved are expended or committed to be expended within three months of the sale;

(21) for SSI, a retroactive social security payment received by the applicant or recipient or an ineligible legally responsible person for the nine months following the month of receipt;

(22) for SSI, pension funds owned by an applicant's or recipient's spouse or parent if the spouse or parent is not an applicant for or recipient of SSI;

(23) for SSI, retirement accounts and pensions of any employed individual who meets the provisions of K.A.R. 30-6-88;

(24) for SSI, the equity value of income-producing personal property, other than cash assets, that is used in an individual's trade or business; and

(25) for SSI, the equity value of non-business income-producing property, other than cash assets, if both of the following conditions are met:

(A) The equity value of income-producing personal property plus the equity value of non-business income-producing real property does not exceed \$6,000.00; and

(B) a net annual return of at least six percent of the total equity is produced.

(e) This regulation shall be effective on and after July 1, 2003. (Authorized by K.S.A. 39-708c;

implementing K.S.A. 39-708c and 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended, T-85-34, Dec. 19, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended, T-30-5-1-90, May 1, 1990; amended, T-30-7-2-90, Aug. 30, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Oct. 1, 1992; amended, T-30-11-16-93, Dec. 1, 1993; amended Jan. 3, 1994; amended July 1, 1994; amended Jan. 1, 1997; amended March 1, 1997; amended Oct. 1, 1997; amended July 1, 2002; amended July 1, 2003.)

**30-6-109w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Chapter 229, Section 104; effective Dec. 30, 1994; amended Jan. 1, 1997; revoked March 1, 1997.)

**30-6-110. Income.** (a) Definitions.

(1) "Earned income" means income, in cash or in kind, that an applicant or recipient currently earns, through the receipt of wages, salary, or profit, from activities in which the individual engages as an employer or as an employee with responsibilities that necessitate continuing activity on the individual's part.

(2) "Unearned income" means all income not earned.

(b) Treatment of income. Except as specified below, income shall be classified as income in the eligibility base period in which it is received; thereafter, it shall be classified as a cash asset.

(1) Prior eligibility. Income received in the three prior months shall be considered in the determination of eligibility for the three prior months, except that self-employment income shall be averaged.

(2) Current eligibility. Income shall be considered prospectively to determine eligibility beginning with the month of application. All income received or reasonably expected to be received shall be considered in determining the applicable income for the eligibility base period. Income from self-employment and intermittent income

shall be considered and averaged. Intermittent income shall be divided by the proper number of months to establish the monthly amount. Intermittent income shall be considered as income beginning with the eligibility base period in which it is received.

(c) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; K.S.A. 1995 Supp. 39-709; effective May, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Oct. 1, 1989; amended Jan. 1, 1990; amended March 1, 1997.)

**30-6-110w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-111. Applicable income.** "Applicable income" means the amount of earned and unearned income that is compared with the appropriate protected income level to establish financial eligibility. (a) Non-SSI. All earned income shall be considered applicable income unless exempted in accordance with K.A.R. 30-6-112 and K.A.R. 30-6-113. Applicable earned income shall be determined as follows.

(1) Applicable earned income for persons included in the assistance plan, and for all persons in the home whose earned income shall be considered and who are excluded from the assistance plan, shall equal gross earned income, or the adjusted gross earned income from self-employment, less \$200.00 per month for each employed person.

(2) For self-employed persons, adjusted gross earned income shall equal gross earned income less cost of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income. A standard deduction of 25% of gross earned income shall be allowed for these costs. If the person wishes to claim actual costs incurred, the following guidelines shall be used by the agency in calculating the cost of the production of the income.

(A) The medical assistance program shall not treat income on the basis of internal revenue serv-



ices (IRS) policies and shall not be used to either subsidize the payment of debts, or set up an individual in a business or a nonprofit activity.

(B) If losses are suffered from self-employment, the losses shall not be deducted from other income, nor shall the net loss of a business be considered as an income-producing cost.

(C) If a business is being conducted from a location other than the applicant's or recipient's home, the expenses for business space and utilities shall be considered as income-producing costs.

(D) If a business is being conducted from a person's own home, shelter and utility costs shall not be considered as income-producing costs unless the person can verify that those costs are clearly distinguishable from operation of the home.

(E) If payments increase the equity in equipment, vehicles, or other property, the payments shall not be considered as an income-producing cost.

(F) If equipment, vehicles, or other property are being purchased on an installment plan, the actual interest paid may be considered as an income-producing cost.

(G) Depreciation on equipment, vehicles, or other property shall not be considered as an income-producing cost.

(H) Insurance payments on equipment, vehicles, or other property shall be allowed if the payments directly relate to the business.

(I) Expenses for inventories and supplies that are reasonable and required for the business shall be considered as income-producing costs.

(J) Wages and other mandated costs related to wages paid by the applicant or recipient may be considered as income-producing costs.

(b) SSI. Applicable earned income shall be determined as follows:

(1) Wages. All earned income shall be considered applicable income except that the provisions of K.A.R. 30-6-112 and K.A.R. 30-6-113 shall apply to persons in an independent living arrangement or in the home- and community-based service program. The applicable earned income shall be gross income less income disregards, if applicable.

(2) Self-employment. The applicable earned income for a self-employed person shall equal the adjusted gross earned income less income disregards, if applicable. The principles set forth in paragraph (a)(2) of this regulation regarding adjusted

gross earned income shall apply to calculations made pursuant to this paragraph.

(c) SSI income disregards.

(1) For persons in an independent living arrangement or in the home- and community-based service program, the following disregards shall apply:

(A) The first \$20.00 of any nonexempt, unearned income; and

(B) an applicable earned income disregard calculated as follows: gross earned income minus any portion of the unearned income disregard that exceeds monthly earned income, plus \$65.00 of monthly earned income, plus  $\frac{1}{2}$  of the remainder of the monthly earned income.

(2) For persons in long-term care who are employed, an applicable earned income disregard shall be calculated as follows: gross earned income minus \$65 of monthly earned income plus  $\frac{1}{2}$  of the remainder of the monthly earned income.

(d) Applicable unearned income.

(1) All net unearned income shall be considered to be applicable income except that the provisions of K.A.R. 30-6-112 and K.A.R. 30-6-113 shall apply to persons in an independent living arrangement or in the home- and community-based service program.

(2) The provisions of K.A.R. 30-6-113 (a), (i), (j), (z), (cc), (ff), and (kk) shall apply to persons in long-term care.

(3) Net unearned income shall equal gross unearned income less the costs of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income. The principles set forth in paragraph (a)(2) of this regulation regarding the calculation of income-producing costs shall apply.

(e) This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended, T-86-9, May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Oct. 1, 1989; amended Jan. 2, 1990; amended April 1, 1990; amended May 1, 1991; amended July 1, 1994; amended Dec. 30, 1994; amended Aug. 1, 1995; amended March 1,

1997; amended July 1, 1998; amended Nov. 1, 1998; amended Jan. 1, 1999.)

**30-6-111w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and K.S.A. 39-7,131; effective Dec. 30, 1994; amended August 1, 1995; revoked March 1, 1997.)

**30-6-112. Income exempt from consideration as income and as a cash asset.** Exempted income shall be the following: (a) Grants and scholarships provided for educational purposes;

(b) the value of benefits provided under the food stamp program;

(c) the value of the U.S. department of agriculture-donated foods;

(d) the value of supplemental food assistance received under the child nutrition act of 1966, as amended, and the special food service program for children under the national school lunch act, as amended;

(e) benefits received under title V, community services employment program, or title VII, nutrition program for the elderly, of the older Americans act of 1965, as amended;

(f) Indian funds distributed or held in trust, including interest and investment income accrued on these funds while held in trust and initial purchases made with these funds;

(g) distributions to natives under the Alaska native claims settlement act;

(h) payments provided to individual volunteers serving as foster grandparents, senior health aides, and senior companions, and to persons serving in the service corps of retired executives and active corps of executives under titles II and III of the domestic service act of 1973;

(i) payments to individual volunteers under title I of public law, sec. 404(g) of public law 93-113 when the director of ACTION determines that the value of these payments, adjusted to reflect the number of hours these volunteers are serving, is less than the federal minimum wage;

(j) payments received under the uniform relocation assistance and real property acquisition policies act of 1970;

(k) death benefits from SSA, VA, railroad retirement, or other burial insurance policy if the benefits are used toward the cost of burial;

(l) money held in trust by VA for a child that VA determines shall not be used for subsistence needs;

(m) retroactive corrective assistance payments in the month received or in the following month;

(n) income directly provided by vocational rehabilitation;

(o) benefits from special government programs at the discretion of the secretary, including energy assistance programs;

(p) reimbursements for out-of-pocket expenses in the month received and the following month;

(q) proceeds from any bona fide loan requiring repayment;

(r) payments granted to certain U.S. citizens of Japanese ancestry and resident Japanese aliens under title I of public law 100-383;

(s) payments granted to certain eligible Aleuts under title II of public law 100-383;

(t) agent orange settlement payments;

(u) federal major disaster and emergency assistance and comparable disaster assistance provided by state or local government or by disaster assistance organizations in conjunction with a presidentially declared disaster;

(v) payments granted to the Aroostook Band of Micmac Indians under public law 102-171;

(w) payments from the radiation exposure compensation trust fund made by the department of justice;

(x) special federal allowances paid monthly to children of Vietnam veterans who are born with spina bifida;

(y) payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer corporation*, except for interest or other investment income earned on such payments;

(z) for non-SSI, a one-time payment or a portion of a one-time payment from a cash settlement for the repair or replacement of property or for legal services, medical costs, or other required obligations to a third party, if the payment is expended or committed to be expended for the intended purpose within six months of its receipt;

(aa) for non-SSI, cash donations that are based on need, do not exceed \$300 in any calendar quarter, and are received from one or more private, nonprofit, charitable organizations;

(bb) for non-SSI, foster care and adoption support payments;

(cc) for non-SSI, the amount of any earned income tax credit received. This credit shall not be regarded as a cash asset in the month of receipt and in the following month;

(dd) for SSI, a one-time payment or a portion of a one-time payment from a cash settlement for the repair or replacement of property or for legal services, medical costs, or other required obligations to a third party, if the payment is expended or committed to be expended for the intended purpose within nine months of its receipt. This time period may be extended for good cause;

(ee) for SSI, in-kind support, vouchers, or cash assistance for food, clothing, or shelter provided by public or private organizations or agencies, if the assistance is based on need;

(ff) for SSI, income necessary for fulfillment of an approved plan to achieve self-support established for a blind or disabled person;

(gg) for SSI, interest that is paid on excluded burial funds and left to accumulate;

(hh) for SSI, housing assistance from federal housing programs operated by state and local subdivisions;

(ii) for SSI, any portion of any financial assistance funded under title IV of the higher education act of 1965, as amended, or under bureau of Indian affairs student assistance programs that is made available for tuition, fees, books, supplies, transportation, and miscellaneous personal supplies;

(jj) for SSI, payments occasioned by the death of another person to the extent that the payments have been expended or committed to be expended for purposes of the deceased person's last illness and burial;

(kk) for SSI, payments received from a state-administered victims' compensation fund. These payments shall not be regarded as a cash asset for the nine months following the month of receipt;

(ll) for SSI, relocation assistance provided by a state or local government that is comparable to assistance provided under title II of the uniform relocation assistance and real property acquisitions act of 1970. This assistance shall not be regarded as a cash asset for the nine months following the month of receipt; and

(mm) for SSI, earnings deposited in an individual development account that meets the provisions of K.A.R. 30-6-109 (d)(9) for a person who meets the provisions of K.A.R. 30-6-88.

This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1,

1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Jan. 1, 1988; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended May 1, 1991; amended July 1, 1991; amended Jan. 2, 1992; amended Oct. 1, 1992; amended Oct. 1, 1993; amended Dec. 30, 1994; amended Oct. 1, 1997; amended July 1, 1998; amended July 1, 2002.)

**30-6-112w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 5; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-113. Income exempt as applicable income.** The following types of income shall be exempt as applicable income in the determination of eligibility: (a) income-in-kind;

(b) shelter cost participation payments. In shared living arrangements in which two families contribute toward the shelter obligations, any cash paid toward the shared shelter obligation by one family to the second family in the shared arrangement shall not be considered as income to the second family. This exemption shall not be applicable in a bona fide, commercial landlord-tenant arrangement;

(c) assistance payments in the month received;

(d) home energy assistance furnished on the basis of need by a federally regulated or state-regulated entity whose revenues are primarily derived on a rate-of-return basis, by a private, non-profit organization, by a supplier of home heating oil or gas, or by a municipal utility company that provides home energy;

(e) income received from the job training partnership act of 1982. However, earnings received by individuals who are participating in on-the-job training programs shall be countable unless the individual is a child;

(f) incentive payments received by renal dialysis patients;

(g) irregular, occasional, or unpredictable monetary gifts that do not exceed \$50.00 per month per family group;

(h) tax refunds and rebates, except for earned income tax credits for non-SSI in accordance with K.A.R. 30-6-112 (y);

(i) VA aid and attendance and housebound allowances;

(j) VA payments resulting from unusual medical expenses;

(k) up to \$2,000.00 per year of income received by an individual Indian that is derived from leases or other uses of an individually owned trust or restricted lands;

(l) lump sum income;

(m) earned income of a child who is under the age of 19 years if the child is a student in elementary or secondary school or is working towards attainment of a G.E.D.;

(n) interest income that does not exceed \$50.00 per month per family group;

(o) for non-SSI, support payments that are covered by an assignment of support rights related to TAF or foster care and that are forwarded to the agency. However, a support refund, disbursed by the agency to the client, shall not be exempt;

(p) for non-SSI, housing assistance from federal housing programs;

(q) for non-SSI, the amount of any child support pass through payment;

(r) for non-SSI the amount of any child support arrearage payment;

(s) for SSI, any refund of taxes paid on real property or on food purchases;

(t) for SSI, one-third of the child support payments received by an eligible child from an absent parent;

(u) for SSI, work expenses of a blind recipient;

(v) for SSI, impairment-related work expenses of a disabled recipient;

(w) for SSI, incentive allowances and reimbursements for individuals in training to provide support services under the jobs training partnership act (JTPA) program administered by the state and local subdivisions;

(x) for SSI, the difference between the social security benefit entitlement in August, 1972, and the entitlement in September, 1972, for persons who were receiving cash assistance through the programs of aid to the aged, blind, or disabled (AABD) or aid to dependent children (ADC) in September, 1972 and who were entitled to a social security benefit in September, 1972. This exemption shall apply only if the exemption establishes eligibility without a spenddown;

(y) for SSI, the amount of all social security cost-of-living adjustments for a person who was concurrently receiving SSI and social security after April, 1977 and who would be eligible for SSI

if the cost-of-living adjustments received since that person was last eligible for SSI were not considered as income;

(z) for SSI, income allocated and expended by an adult in an institutional living arrangement for the support of the adult's minor children if the adult does not have a spouse who continues to live in the community. The income allocation shall not exceed the amount necessary to bring the children's income up to the protected income level appropriate to their living arrangement;

(aa) for SSI, SSI payments that the person is not legally entitled to receive and that are subject to SSI recovery;

(bb) for SSI, the amount of the December, 1983 increase in social security disabled widow or widower benefits resulting from the changes in the actuarial reduction formula, and all subsequent cost-of-living adjustments, for a person who was concurrently receiving SSI and social security disabled widow and widower benefits under section 202(e) or 202(f) of the social security act, when the person meets all of the following conditions.

(1) The person became ineligible for SSI due solely to the 1983 actuarial increase.

(2) The person has continually received social security disabled widow or widower benefits since the 1983 actuarial increase was first received.

(3) The person would be currently eligible for SSI if it were not for the 1983 actuarial increase and all subsequent cost-of-living adjustments.

(4) The person applied for medical assistance under this provision prior to July 1, 1988.

(cc) for SSI, reparation payments made under the Republic of Germany's federal law for compensation of nationalist socialist persecution;

(dd) for SSI, the amount of the social security adult disabled child benefit for an otherwise eligible SSI person age 18 or older who meets both of the following conditions.

(1) The person was receiving SSI benefits that began prior to age 22.

(2) The person lost SSI eligibility due solely to the person's becoming eligible for the adult disabled child benefits or to an increase in the adult disabled child benefits.

(ee) for SSI, the amount of social security early or disabled widow or widower benefits under section 202(e) or (f) of the social security act, if the person meets all of the following conditions.

(1) The person became ineligible for SSI because of the receipt of such benefits.



(2) The person would be currently eligible for SSI in the absence of such benefits.

(3) The person is not entitled to hospital insurance benefits under Part A of title XVIII of the social security act.

(ff) for SSI, the income of an SSI recipient that exceeds the protected income level for institutionalized persons for three months following the month of admission, when the social security administration determines that the stay in the institution is temporary and the person needs to continue to maintain and provide for the expenses of the home or another living arrangement to which the person may return;

(gg) for SSI, the income of an applicant's or recipient's spouse or parent that was counted or excluded in determining the amount of a public assistance payment, if the spouse or parent is not an applicant for or recipient of SSI;

(hh) for SSI, the income of an applicant's or recipient's spouse or parent that is used to make support payments under a court order or title IV-D support order, if the spouse or parent is not an applicant for or recipient of SSI;

(ii) for SSI, the amount of VA pension received by a single veteran with no dependents or a surviving spouse with no children, if the pension has been reduced to \$90.00 or less because the veteran or spouse resides in a medicaid-approved nursing facility;

(jj) for SSI, foster care and adoption support payments;

(kk) for SSI, Austrian social insurance payments based, in whole or in part, on wage credits granted under the Austrian general social insurance act; and

(ll) for SSI, hostile fire pay received while in active military service.

This regulation shall take effect on and after October 1, 1997. (Authorized by and implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Jan. 1, 1988; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended, T-30-12-

28-90, Jan. 2, 1991; amended May 1, 1991; amended July 1, 1991; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; amended Jan. 4, 1993; amended May 3, 1993; amended, T-30-11-16-93, Dec. 1, 1993; amended Jan. 3, 1994; amended Sept. 30, 1994; amended Dec. 30, 1994; amended March 1, 1997; amended July 1, 1997; amended Oct. 1, 1997.)

**30-6-113w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

**30-6-114 to 30-6-119. Reserved.**

**30-6-120. Eligibility prior to the month of application.** If requested, the eligibility of an applicant for the medical assistance program shall be determined for the three months immediately prior to the month of application. (a) Automatic eligibles. The applicant shall be eligible for medical assistance in any of the three months in which the applicant would have been automatically eligible for medical assistance if the applicant would have applied for medical assistance during the month.

(b) Determined eligibles. The prior eligibility base period shall begin on the first day of the first month in which all eligibility factors other than financial are met without regard to current eligibility. (Authorized by and implementing K.S.A. 1982 Supp. 39-708c, 39-709; effective May 1, 1981; amended May 1, 1983.)

**30-6-121 to 30-6-139. Reserved.**

**30-6-140. Payment amounts.** (a) Underpayments. Underpayments shall be promptly corrected, subject to the requirement that the provider shall bill the agency for the expense within the mandatory 12-month limitation period. When eligibility was incorrectly denied, and if it is documented that the provider will not return payment to the individual, the individual shall be reimbursed for the verified amounts paid to the provider, up to the proper rate for the service.

(b) Overpayments. Overpayments may be recovered by voluntary repayment, administrative recoupment, or legal action.

(1) The administrative recovery process may be utilized in all cases in which an overpayment has occurred, including overpayments for automatic eligibles. The overpayment shall be deemed to be a spenddown requirement and shall be con-

sidered in determining the person's spenddown requirement for the current eligibility base period. If the spenddown requirement is not met in total during the initial eligibility base period, the unmet portion of the spenddown shall be considered as a spenddown requirement for the subsequent eligibility base period. This process shall be repeated for subsequent eligibility base periods until the spenddown requirement has been met in total. The person shall not be eligible for assistance until the spenddown requirements are met.

(2) Administrative recoupment procedures shall not be initiated by the agency pending the disposition of a welfare fraud referral.

(c) Welfare fraud penalty. Any person convicted of medical assistance program fraud, pursuant to section 1909 of the federal social security act, shall be ineligible to participate in the medical assistance program for a period of one year from the date of the conviction.

(d) Discontinuance of assistance. Any recipient's participation in the medical assistance program shall be discontinued when the recipient no longer meets one or more of the appropriate factors of eligibility.

(e) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended March 1, 1997.)

**30-6-150. Estate recovery.** (a) A claim against the property and estate of a deceased recipient shall be established for the amount of any medical assistance paid after June 30, 1992 on that person's behalf if the recipient:

(1) Was 55 years of age or older or was institutionalized while receiving such assistance; and

(2) has no surviving spouse or no surviving child who is under 21 years of age or meets the disability criteria of K.A.R. 30-6-85(c).

(b) If there is no estate, a claim shall be filed against the estate of the surviving spouse, if any.

(c) No recovery of medical assistance correctly paid shall occur until the death of the surviving spouse, if any, and at the time when the deceased individual has no surviving child under 21 years of age or who is disabled as specified in subsection (a).

(d) The amount of medical assistance paid shall

be a claim against the estate in any guardianship or conservator proceeding.

(e) The secretary shall not be required to pursue every claim but shall have discretion in determining which claims to pursue.

(f) The monetary value of any benefits paid on behalf of a recipient under long-term care insurance, as defined by K.S.A. 1992 Supp. 40-2227 and amendments thereto, shall be a credit against the estate claim under this provision.

(g) Transfers of real or personal property by a recipient for less than fair market value shall be voidable and may be set aside. Fair market value shall be based on the percentage of ownership of the property. For real or personal property which is jointly owned, the value of the property shall be prorated to determine percentage of ownership unless otherwise specified in deed or title.

(h) The provisions of this regulation shall be waived if the application of the provisions would result in an undue hardship as determined on the basis of criteria established by the secretary of health and human services. (Authorized by K.S.A. 1992 Supp. 39-708c; implementing K.S.A. 1992 Supp. 39-708c, and 39-709, as amended by L. 1993, Chapter 180, Sec. 1; effective, T-30-6-10-92, July 1, 1992; effective Oct. 1, 1992; amended Jan. 4, 1993; amended May 3, 1993; amended, T-30-11-16-93, Dec. 1, 1993; amended Jan. 3, 1994.)

**30-6-150w.** This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

## **Article 7.—APPEALS, FAIR HEARINGS AND TAF/GA DISQUALIFICATION HEARINGS**

**30-7-1.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-2.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1976; revoked May 1, 1981.)

**30-7-3.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-4.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended May 1, 1975; revoked May 1, 1981.)

**30-7-5.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; amended May 1, 1978; revoked May 1, 1981.)

**30-7-6.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1969; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; amended May 1, 1978; revoked May 1, 1981.)

**30-7-7 and 30-7-8.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-9 and 30-7-10.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-11.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-7-12.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-13.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-14.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended, E-74-45, Aug.

28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-15.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-16.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-17.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1973; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-18.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-19.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-20.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended, E-74-45, Aug. 28, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-21 and 30-7-22.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1974.)

**30-7-23.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-24.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended May 1, 1975; revoked May 1, 1981.)

**30-7-25.** (Authorized by K.S.A. 75-3306, K.S.A. 1980 Supp. 39-708c; effective, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1,

1974; amended May 1, 1975; revoked May 1, 1981.)

**30-7-26 to 30-7-29.** These regulations shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; revoked July 1, 1989.)

**30-7-30.** This regulation shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; amended May 1, 1986; revoked July 1, 1989.)

**30-7-31 to 30-7-34.** These regulations shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; revoked July 1, 1989.)

**30-7-35.** This regulation shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; amended May 1, 1986; revoked July 1, 1989.)

**30-7-36 to 30-7-39.** These regulations shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; revoked July 1, 1989.)

**30-7-40.** This regulation shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; amended May 1, 1986; revoked July 1, 1989.)

**30-7-41 to 30-7-53.** These regulations shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; revoked July 1, 1989.)

**30-7-54.** This regulation shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; amended May 1, 1986; revoked July 1, 1989.)

**30-7-55.** This regulation shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; amended May 1, 1982; revoked July 1, 1989.)

**30-7-56 to 30-7-63.** These regulations shall expire on July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective May 1, 1981; revoked July 1, 1989.)

**30-7-64. Definitions.** (a) "Appellant" means an individual or entity that has requested a fair hearing from an agency decision affecting the individual or entity.

(b) "Applicant" means an individual who has

applied for or requested assistance or benefits from a program administered by the agency.

(c) "Recipient" means an individual who is receiving assistance or benefits from a program administered by the agency. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-65. Notice to recipients of intended action.** (a) (1) "Adequate notice" means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific policies supporting the action, an explanation of the individual's right to request a fair hearing, and the circumstances under which assistance is continued if a hearing is requested.

(2) "Timely" means that the notice is mailed at least 10 days before the date upon which the action would become effective. Saturdays, Sundays, and legal holidays shall be counted as part of the 10-day period.

(b) When the agency intends to take action to discontinue, terminate, suspend, or reduce assistance, timely and adequate notice shall be given by the agency, except as set forth in subsection (c) of this regulation.

(c) Under the following circumstances, timely notice shall not be required, but an adequate notice shall be sent by the agency not later than the date of action:

(1) when the agency has factual information confirming the death of a recipient or of the TAF payee and there is no relative available to serve as a new payee;

(2) when the agency receives a clear written statement signed by a recipient indicating that the recipient no longer wishes assistance;

(3) when the recipient provides written information to the agency that requires termination or reduction of assistance, and the recipient has indicated, in writing, an understanding that termination or reduction of assistance will be the consequence of supplying the information;

(4) when the recipient has been admitted or committed to an institution and further payments to that individual are not authorized by program regulations as long as the person resides in the institution;

(5) when the recipient has been placed in



skilled nursing care, intermediate care or long-term hospitalization;

(6) when the recipient's whereabouts are unknown and agency mail directed to the recipient has been returned by the post office indicating no known forwarding address. However, the check shall be made available to the recipient if the recipient's whereabouts become known during the payment period covered by a returned check;

(7) when the agency has established that a recipient has been accepted for assistance in a new jurisdiction;

(8) when a child is removed from the home as a result of a judicial determination or voluntarily placed in foster care by the child's legal guardian;

(9) when a change in the level of medical care is prescribed by the recipient-patient's physician;

(10) when a special allowance granted for a specific period is terminated and the recipient was informed in writing at the time the allowance was granted that it would automatically terminate at the end of the specified period;

(11) when the agency takes action because of information the recipient furnished in a monthly status report or because the recipient has failed to submit a complete or a timely monthly status report without good cause; or

(12) when the recipient is disqualified due to fraud in one of the following ways:

(A) by a court of appropriate jurisdiction;

(B) by an administrative disqualification hearing process in accordance with K.A.R. 30-7-102; or

(C) through a waiver of an administrative disqualification hearing in accordance with K.A.R. 30-7-103.

(d) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended July 1, 1991; amended Jan. 1, 1997; amended March 1, 1997.)

**30-7-66. Continuation of assistance.** (a) If the recipient requests a hearing within the timely notice period as required by K.A.R. 30-7-65, assistance shall not be suspended, reduced, discontinued, or terminated, (but is subject to recovery by the agency if its action is sustained), until an initial decision of the hearing officer is rendered in the matter, unless:

(1) The request for fair hearing concerns the suspension of program payments to a provider or

the termination of a provider from program participation;

(2) the request for a fair hearing concerns a discontinued program or service;

(3) a determination is made by the hearing officer that the sole issue is one of federal or state law, regulation or policy, or change in federal or state law, regulation or policy and not one of incorrect grant computation; or

(4) a change affecting the recipient's assistance occurs while the hearing decision is pending and the recipient fails to request a hearing after notice of the change.

(b) The agency shall promptly inform the recipient in writing if assistance is to be discontinued pending the hearing decision.

(c) In any case where action was taken without timely notice, if the recipient requests a hearing within 10 days of the mailing of the notice of the action, and the agency determines that the action resulted from other than the application of federal or state law or policy or a change in federal or state law, assistance shall be reinstated and continued until a decision is rendered in the matter except as set forth in (a)(1), (2), (3), or (4). The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-67. Administrative hearings section, hearing officer.** The administrative hearings section shall administer the agency's fair hearing program. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-68. Request for fair hearing.**

(a) Unless preempted by federal law, a request for fair hearing shall be in writing and received by the agency within 30 days from the date of the order or notice of action. Pursuant to K.S.A. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(b) A request for fair hearing involving food stamps shall be received by the agency within 90 days from the date of the notice of action. Pursuant to K.S.A. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(c) The freedom to request a fair hearing shall not be limited or interfered with by the agency. The effective date of this regulation shall be Jan-

uary 2, 1991. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended Jan. 7, 1991.)

**30-7-69. Pre-appeal administrative remedies.** (a) A pre-appeal administrative remedy is any procedure or process, the purpose of which is to encourage settlement or otherwise resolve the dispute before appeal to the administrative hearings section.

(b) Pre-appeal administrative remedies are to be encouraged to promote the resolution of disputes between the parties involved. Pre-appeal administrative remedies may also be used by the parties to narrow and define the issues to be appealed to the administrative hearings section. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-70. Agency's review of decision.** (a) Upon receipt of notice that a request for fair hearing has been made, the agency shall review its action or decision. Upon reconsideration, the agency may amend or change its action or decision before or during the hearing.

(b) If a satisfactory adjustment is reached prior to the hearing, the agency shall submit a report to the hearing officer, in writing, but the appeal shall remain pending until the appellant submits a signed, written statement withdrawing the appellant's request for fair hearing. If the appellant fails to timely submit a signed, written statement withdrawing the request for fair hearing, the hearing officer may dismiss the request for fair hearing. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-71. Venue.** (a) Fair hearings for applicants or recipients shall be held in the social and rehabilitation services' administrative area in which the applicant or recipient resides unless another site has been designated by the hearing officer or the hearing is conducted pursuant to the provisions of K.A.R. 30-7-72.

(b) Fair hearings for other appellants shall be held in Topeka, Kansas unless another site has been designated by the hearing officer or the hearing is conducted pursuant to the provisions of K.A.R. 30-7-72. The effective date of this regu-

lation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-72. Telephone hearings.** The hearing officer may conduct the fair hearing or any prehearing by telephone or other electronic means if each participant in the hearing or prehearing has an opportunity to participate in the entire proceeding while the proceeding is taking place. A party may be granted a face to face hearing or prehearing if good cause can be shown that a fair and impartial hearing or prehearing could not be conducted by telephone or other electronic means. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-73. Summary reversals.** The hearing officer may, without notice or hearing, summarily reverse the agency's decision or action in the matter if it is clear from the agency's summary that the agency's decision or action was incorrect. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-74. Independent medical, psychiatric and psychological examinations.** When the hearing involves medical, psychiatric or psychological issues, the hearing officer may order on the hearing officer's own motion that an independent medical, psychiatric or psychological assessment other than that of the person or persons involved in making the original decision shall be obtained at agency expense and made part of the record if the hearing officer considers it necessary. If a party requests the independent assessment, that party shall pay the costs incurred in obtaining the assessment. If the party requesting the assessment signs a poverty affidavit, the independent medical, psychiatric or psychological assessment shall be performed at agency expense. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

**30-7-75. Agency's summary.** Within 15 days after notification of the request for fair hearing the agency shall furnish the appellant and the

administrative hearings section with a summary setting forth the following information:

- (a) Name and address of the appellant;
- (b) a summary statement concerning why the appellant is filing a request for a fair hearing;
- (c) a brief chronological summary of the agency's action in relationship to the appellant's request for a fair hearing;
- (d) a statement of the basis of the agency's decision;
- (e) a citation of the applicable policies relied upon by the agency;
- (f) a copy of the notice which notified appellant of the decision in question;
- (g) applicable correspondence; and
- (h) the name and title of the person or persons who will represent the agency at the hearing. The effective date of this regulation shall be July 1, 1991. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended July 1, 1991.)

**30-7-76. Transcripts.** (a) A transcript of the hearing may be prepared if requested by an appellant, the agency, the hearing officer, the state appeals committee or the secretary. The party requesting the transcript or review of the hearing officer's decision shall pay any costs associated in obtaining a transcript.

(b) If an appellant requests a transcript, the agency shall pay the costs of transcribing the recording if the appellant signs a poverty affidavit.

(c) If a transcript is prepared, the reporter shall sign the following certification on all copies: "This is to certify that \_\_\_\_\_

Name of Hearing Officer

conducted a hearing on the application of \_\_\_\_\_ in \_\_\_\_\_

Name of Appellant

county, state of Kansas, on \_\_\_\_\_

Date

at \_\_\_\_\_ and that the foregoing is a true and correct transcript of the record of the hearing."

\_\_\_\_\_  
Signature of Reporter

The effective date of this regulation shall be January 2, 1992. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Jan. 2, 1992.)

**30-7-77. Rehearing.** (a) Any party, within 15 days after service of the hearing officer's decision, may file a petition for rehearing with the administrative hearings section, stating the spe-

cific grounds upon which the rehearing of the hearing officer's decision is requested.

(b) A rehearing may be granted to either party on all or part of the issues when it appears that the rights of the party are substantially affected because:

(1) Of an erroneous ruling of the hearing officer;

(2) the decision in whole or in part is contrary to the evidence; or

(3) of newly discovered evidence which the moving party could not with reasonable diligence have discovered or produced at the hearing.

(c) The filing of a petition for rehearing is not a prerequisite for review at any stage of the proceedings. The filing of a petition for rehearing does not stay any time limits or further proceedings that may be conducted under the Kansas administrative procedures act, K.S.A. 77-501 et seq. and amendments thereto, or any other provision of law. The effective date of this regulation shall be January 2, 1992. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Jan. 2, 1992.)

**30-7-78. State appeals committee.** (a) The secretary may appoint one or more state appeals committees to review the decisions or orders of hearing officers.

(b) The committees shall consist of three impartial persons.

(c) Decisions of the committee shall be by majority vote.

(d) The record, as defined in K.S.A. 77-532, shall be the basis for the state appeals committee review. The effective date of this regulation shall be January 2, 1992. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Jan. 2, 1992.)

**30-7-79. Motions.** (a) Motions, unless made during a hearing, shall:

(1) Be in writing; and

(2) state with particularity their bases.

(b) The opposing party shall have 15 days from the date of mailing or personal delivery within which to file a response. The hearing officer may waive the deadline for good cause.

(c) The hearing officer on his or her own motion or at the request of either party may conduct a hearing on the motion. A party requesting a hearing shall include the request in the motion or response. The effective date of this regulation shall be August 1, 1990. (Authorized by K.S.A. 75-

3304; implementing K.S.A. 75-3306; effective Aug. 1, 1990.)

**30-7-100. Definition of intentional TAF or GA program violation.** (a) An “intentional program violation” means any action taken by an individual to establish or maintain a family’s eligibility for temporary assistance for families (TAF) or general assistance (GA), or to obtain an increase in or to maintain the amount of the family’s TAF or GA grant, when that action constitutes either of the following:

(1) an intentionally false or misleading statement, misrepresentation, concealment, or withholding of facts; or

(2) an act intended to mislead, misrepresent, conceal, withhold facts, or propound a falsity.

(b) This regulation shall take effect on and after March 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Chapter 229, Sec. 104; effective July 31, 1992; amended May 3, 1993; amended March 1, 1997.)

**30-7-101. Administrative hearings section, hearing officer.** The disqualification hearing program shall be administered by the administrative hearings section of the agency. The effective date of this regulation shall be July 31, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c; effective July 31, 1992.)

**30-7-102. Disqualification hearings.** (a) An individual’s fair hearing may be consolidated with a disqualification hearing by the agency when the circumstances surrounding the hearings are the same or related, provided that the individual receives prior notice of the consolidation. Either the hearing officer for the fair hearing or the hearing officer for the disqualification hearing may be assigned by the agency to preside at a consolidated hearing.

(b) The hearing officer shall:

(1) administer oaths and affirmations;

(2) consider all relevant issues;

(3) request, receive and make part of the record all evidence necessary to decide the issues raised;

(4) conduct the hearing in a manner consistent with due process;

(5) advise the accused individual that the individual may refuse to answer questions during the hearing; and

(6) render a final decision that will resolve the issues in dispute.

(c) The hearing officer shall base a determination of intentional program violation on clear and convincing evidence which demonstrates that the individual committed an intentional program violation.

(d) The hearing officer shall conduct the fair hearing or any prehearing by telephone or other electronic means if each participant in the hearing or prehearing has an opportunity to participate in the entire proceeding while the proceeding is taking place. A party may be granted a face to face hearing or prehearing if good cause is shown that a fair and impartial hearing or prehearing could not be conducted by telephone or electronic means.

(e) (1) A written notice shall be provided by the agency to the individual alleged to have committed the intentional program violation at least 30 days before the date of the disqualification hearing.

(2) The advance written notice to the individual shall include the following items:

(A) The date, time and location of the hearing;

(B) the charge or charges against the individual;

(C) a summary of the evidence, and how and where the evidence can be examined;

(D) a warning that the individual’s failure to appear without good cause will result in a decision by the hearing officer based solely on the information provided by the agency at the hearing;

(E) a statement that the individual may request a postponement of the hearing if the request is made to the state agency at least 10 days before the scheduled hearing;

(F) a statement that the individual will have 10 days from the date of the scheduled hearing to present to the agency good cause for failure to appear in order to receive a new hearing;

(G) a description of the penalties that can result from a determination that the individual has committed an intentional program violation and a statement of which penalty applies to the individual;

(H) a statement that the hearing does not preclude the state government from prosecuting the individual for an intentional program violation in a civil or criminal court action, or from collecting an overpayment;

(I) information regarding free legal represen-



tation available to individuals alleged to have committed intentional program violations;

(J) a statement of the accused individual's right to remain silent concerning the charge or charges and that anything said or signed by the individual concerning the charge or charges may be used against the individual in a court of law;

(K) a statement that the individual may waive the right to appear at an administrative disqualification hearing;

(L) (i) the date that the signed waiver shall be received by the agency;

(ii) a signature block for the accused individual;

(iii) a statement that the caretaker relative shall also sign the waiver if the accused individual is not the caretaker relative; and

(iv) a signature block designated for the caretaker relative;

(M) a statement that waiver of the individual's right to appear at a disqualification hearing may result in a disqualification penalty and a reduction in the assistance payment for the appropriate period even if the accused individual does not admit to the facts as presented by the agency; and

(N) an opportunity for the accused individual to specify whether the individual admits to the facts as presented by the agency.

(f) (1) The hearing officer shall postpone the scheduled hearing at the individual's request provided the request for postponement is made at least 10 days before the scheduled disqualification hearing;

(2) the hearing officer shall not postpone for more than a total of 30 days; and

(3) the hearing officer may limit the number of postponements to one.

(g) The hearing officer assigned to conduct the hearing shall be impartial and not previously involved in the case.

(h) Medical assessments shall be obtained by the agency at the agency's expense and shall be made part of the record if the hearing officer considers it necessary.

(i) The individual, or the individual's representative, shall have adequate opportunity to:

(1) examine the contents of the individual's case file, and all documents and records to be used by the agency at the hearing at a reasonable time before the date of the hearing and during the hearing;

(2) present the individual's case alone or with the aid of an authorized representative;

(3) bring witnesses;

(4) establish all pertinent facts and circumstances;

(5) advance any arguments without undue influence; and

(6) question or refute any testimony or evidence, confronting and cross-examining adverse witnesses.

(j) Decisions made by the hearing officer shall be based exclusively on the evidence and other material admitted into the case record at the hearing. The transcript or recording of testimony, exhibits, or official reports admitted at the hearing, together with all papers and requests filed in the proceeding, and the decision of the hearing officer shall be made available to the individual or to the individual's representative at a reasonable time and place.

(k) Decisions by the hearing officer shall:

(1) consist of a decision memorandum summarizing the facts, evidence and regulations supporting the decision; and

(2) be made within 90 days of the date of service of the notice of hearing.

(l) An individual shall not be disqualified by the agency per this section until the hearing officer finds that the individual has committed an intentional program violation. However, assistance may be discontinued, terminated, suspended, or reduced by the agency, or changed in the manner or form of payment to a protective, vendor, or two-party payment for other reasons.

(m) If the hearing officer finds that the individual committed an intentional program violation, a written notice shall be provided by the agency to the individual before disqualification. The notice shall inform the individual of the following:

(1) the decision and the reason for the decision;

(2) the period of disqualification, which shall begin not later than the first day of the second month which follows the date of the notice;

(3) the amount of payment the household will receive during the disqualification period; and

(4) the individual's right to appeal the decision to the district court of Shawnee county or the individual's county within 30 days of the date of the decision and that an appeal may result in a reversal of the decision.

(n) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c; effective July 31, 1992; amended July 1, 1996.)

**30-7-103. Waiver of the administrative disqualification hearing.** (a) An individual shall be allowed by the agency to waive the right to appear at an administrative disqualification hearing.

(b) When the individual waives the right to appear at a disqualification hearing, the individual shall be disqualified and shall be subject to appropriate reduction of assistance regardless of whether the individual admits or denies the charges. A written notice shall be sent by the agency informing the individual of the period of disqualification, which shall begin not later than the first day of the second month which follows the date of notice, and the amount of payment the household will receive during the disqualification period.

(c) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c; effective July 31, 1992; amended July 1, 1996.)

**30-7-104. Court actions on consent agreements.** (a) An accused individual shall be allowed by the agency to sign a written agreement confirmed by a court of competent jurisdiction in which the individual admits committing an intentional program violation.

(b) The written agreement shall include the following:

(1) a statement that the individual understands the consequences of signing the agreement;

(2) a statement that the caretaker relative must also sign the agreement if the accused is not the caretaker relative; and

(3) a statement that signing the agreement will result in a reduction in payment for the appropriate period.

(c) After the court confirms the agreement, a written notice shall be provided by the agency to the individual which specifies the period of disqualification, which shall begin not later than the first day of the second month which follows the date of the notice, and the amount of payment the household will receive during the disqualification period. If the court specifies the date for initiating the disqualification period, the accused individual shall be disqualified by the agency in accordance with the court order.

(d) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c; effective July 31, 1992; amended July 1, 1996.)

## Article 8.—PERSONNEL

**30-8-1 to 30-8-6.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1974.)

**30-8-7.** (Authorized by K.S.A. 1971 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1972.)

**30-8-8.** (Authorized by K.S.A. 1971 Supp. 39-708; effective Jan. 1, 1967; revoked, E-71-25, June 11, 1971; revoked Jan. 1, 1972.)

**30-8-9.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; amended, E-71-25, June 11, 1971; amended Jan. 1, 1972; revoked Jan. 1, 1974.)

**30-8-10 and 30-8-11.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1974.)

**30-8-12.** (Authorized by K.S.A. 1971 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1972.)

**30-8-13 and 30-8-14.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1974.)

**30-8-15.** (Authorized by K.S.A. 75-3304, K.S.A. 1968 Supp. 39-708; effective Jan. 1, 1969; revoked Jan. 1, 1974.)

## Article 9.—ADULT CARE PROGRAM

**30-9-1.** (Authorized by K.S.A. 39-708c; effective, E-72-23, July 28, 1972; effective Jan. 1, 1973; amended Jan. 1, 1974; revoked, E-74-43, Aug. 16, 1974; revoked May 1, 1975.)

**30-9-2 and 30-9-3.** (Authorized by K.S.A. 39-708c; effective, E-72-23, July 28, 1972; effective Jan. 1, 1973; revoked, E-74-43, Aug. 16, 1974; revoked May 1, 1975.)

**30-9-4.** (Authorized by K.S.A. 39-708c; effective, E-72-23, July 28, 1972; effective Jan. 1, 1973; amended Jan. 1, 1974; revoked, E-74-43, Aug. 16, 1974; revoked May 1, 1975.)

**30-9-5.** (Authorized by K.S.A. 39-708c; effective, E-72-23, July 28, 1972; effective Jan. 1, 1973; revoked, E-74-43, Aug. 16, 1974; revoked May 1, 1975.)

**30-9-6 to 30-9-11.** (Authorized by K.S.A. 39-708c; effective, E-72-23, July 28, 1972; effective

tive Jan. 1, 1973; amended Jan. 1, 1974; revoked, E-74-43, Aug. 16, 1974; revoked May 1, 1975.)

**30-9-12.** (Authorized by K.S.A. 39-708c; effective, E-72-23, July 28, 1972; effective Jan. 1, 1973; amended Jan. 1, 1974; amended, E-74-25, April 26, 1974; revoked, E-74-43, Aug. 16, 1974; revoked May 1, 1975.)

**30-9-13.** (This rule and regulation shall expire on July 31, 1992. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, L. 1989, Chapter 191; effective Jan. 1, 1990; revoked July 31, 1992.)

**30-9-14 to 30-9-17. Reserved.**

**30-9-18 through 30-9-22.** These rules and regulations shall expire on July 31, 1992. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c, L. 1989, Chapter 191; effective Jan. 1, 1990; revoked July 31, 1992.)

#### **Article 10.—ADULT CARE HOME PROGRAM**

**30-10-1.** (Authorized by and implementing K.S.A. 39-708c; effective, E-74-43, Aug. 16, 1974; amended, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1982.)

**30-10-1a. Nursing facility program definitions.** (a) The following words and terms, when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

(1) “Accrual basis of accounting” means that revenue of the provider is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) “Active treatment for individuals with mental retardation or a related condition” means a continuous program for each client, which shall include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed toward the following:

(A) The acquisition of the behaviors necessary

for the client to function with as much self-determination and independence as possible; and

(B) the prevention or deceleration of regression or loss of current optimal functional status.

(3) “Agency” means the department of social and rehabilitation services.

(4) “Ancillary services and other medically necessary services” means those special services or supplies, in addition to routine services, for which charges are made.

(5) “Case mix” means a measure of the intensity of care and services used by a group of residents in a facility.

(6) “Case mix index” means a numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample. Two average case mix index scores are considered in setting rates for nursing facility program participants. These indexes are the following:

(A) “Medicaid average case mix index,” which means the average case mix index calculated using case mix scores for only the medicaid residents in a population; and

(B) “facility average case mix index,” which means the average case mix index calculated using case mix scores for all the residents in a nursing facility.

(7) “Change of ownership” means a transfer of rights and interests in real and personal property used for nursing facility services through an arm’s-length transaction between unrelated persons or legal entities.

(8) “Change of provider” means a change of ownership or lessee specified in the provider agreement.

(9) “Common ownership” means that an entity holds a minimum of five percent ownership or equity in the provider facility or in a company engaged in business with the provider facility.

(10) “Control” means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(11) “Cost and other accounting information” means adequate financial data about the nursing facility operation, including source documentation, that is accurate, current, and sufficiently detailed to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if the documentation originated

at the time and near the place of the transaction. In order to provide the required cost data, the provider shall maintain financial and statistical records in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

(12) "Cost finding" means recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(13) "Costs not related to resident care" means costs that are not appropriate, necessary, or proper in developing and maintaining the nursing facility operation and activities. These costs shall not be allowed in computing reimbursable costs.

(14) "Costs related to resident care" means all necessary and proper costs, arising from arm's-length transactions in accordance with general accounting rules, that are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-23a, K.A.R. 30-10-23b, K.A.R. 30-10-23c, K.A.R. 30-10-24, K.A.R. 30-10-25, K.A.R. 30-10-26, K.A.R. 30-10-27, and K.A.R. 30-10-28.

(15) "Cost report" means the nursing facility financial and statistical report (MS-2004).

(16) "Educational activities" means an approved, formally organized, or planned program of study usually engaged in by providers in order to enhance the quality of resident care in an institution. These activities shall be licensed when required by state law.

(17) "Educational activities—net cost" means the cost of approved educational activities less any grants, specific donations, or reimbursements of tuition.

(18) "Hospital-based nursing facility" means a nursing facility, as defined in this regulation, that is attached to or associated with a hospital.

(19) "Inadequate care" means any act or failure to act that may be physically or emotionally harmful to a recipient.

(20) "Level of care" means the type and intensity of services prescribed in the resident's plan of care as based on the assessment and reassessment process.

(21) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function.

Relevant diagnoses shall be limited to schizophrenia, recurrent and severe major affective disorders, atypical psychosis, bipolar disorder, paranoid disorders, schizoaffective disorder, psychotic disorder, obsessive-compulsive disorder, or borderline personality disorder.

(22) "Mental retardation" means subaverage general intellectual functioning that originates in the developmental period and is associated with an impairment in adaptive behavior.

(23) "Nonworking owners" means any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the nursing facility.

(24) "Nonworking related party or director" means any related party, as defined in this regulation, who does not perform a resident-related function for the nursing facility.

(25) "Nursing facility (NF)" means a facility that conforms to these criteria:

(A) Meets state licensure standards;

(B) provides health-related care and services, as prescribed by a physician; and

(C) provides 24-hour-a-day, seven-day-a-week licensed nursing supervision to residents for ongoing observation, treatment, or care for long-term illness, disease, or injury.

(26) "Nursing facility for mental health" means a nursing facility that meets these criteria:

(A) Meets state licensure standards;

(B) provides structured mental health rehabilitation services, in addition to health-related care, for individuals with a severe and persistent mental illness; and

(C) provides 24-hour-a-day, seven-day-a-week licensed nursing supervision. The nursing facility shall have been operating in accordance with a provider agreement with the agency on June 30, 1994.

(27) "Ongoing entity" means that a change in the provider has not been recognized for Kansas medical assistance program payment purposes.

(28) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of legal business entity. These costs shall be considered to be intangible assets representing expenditures for rights and privileges that have value to the business.

(29) "Owner and related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf of any owner with a five percent or greater interest in the provider or any related party, as defined in this regulation,



whether the payment is from a sole proprietorship, partnership, corporation, or nonprofit organization.

(30) “Owner” means the person or legal entity that has the rights and interests of the real and personal property used to provide the nursing facility services.

(31) “Plan of care for nursing facilities” means a document completed by the nursing facility staff that states the need for care, the estimated length of the program, the methodology to be used, and the expected results for each resident.

(32) “Prescription drug” means a simple or compound substance or mixture of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that is prescribed by a licensed physician or practitioner and dispensed by a licensed pharmacist.

(33) “Projected cost report” means a cost report submitted to the agency by a provider prospectively for a 12-month period of time. The projected cost report shall be based on an estimate of the costs, revenues, resident days, and other financial data for that 12-month period of time.

(34) “Provider” means the operator of the nursing facility specified in the provider agreement.

(35) “Recipient” means a person determined to be eligible for the Kansas medical assistance program in a nursing facility.

(36) “Related parties” means two or more parties with a relationship in which one party has the ability to influence another party to the transaction in the following manner:

(A) When one or more of the transacting parties might fail to pursue the party’s or parties’ own separate interests fully;

(B) when the transaction is designed to inflate the Kansas medical assistance program costs; or

(C) when any party considered a related party to a previous owner or operator becomes the employee, or otherwise functions in any capacity on behalf of a subsequent owner or operator. Related parties shall include parties related by family, business, or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm’s-length negotiations.

(37) “Related to the nursing facility” means that the facility is significantly associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(38) “Representative” means either of the following:

(A) A legal guardian, conservator, or representative payee as designated by the social security administration; or

(B) any person who is designated in writing by the resident to manage the resident’s personal funds and who is willing to accept the designation.

(39) “Resident assessment form” means the document that meets these requirements:

(A) Is jointly specified by the Kansas department of health and environment and the agency;

(B) is approved by the health care finance administration; and

(C) includes the minimum data set.

(40) “Resident assessment instrument” means the resident assessment form, resident assessment protocols, and the plan of care, including reassessments.

(41) “Resident day” means that period of service rendered to a resident between census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Kansas medical assistance program or non-Kansas medical assistance program resident who was not in the nursing facility. Census-taking hours shall consist of 24 hours beginning at midnight.

(42) “Resident status review” means a reassessment to identify any nursing facility resident who may no longer meet the level of care criteria.

(43) “Routine services and supplies” means services and supplies that are commonly stocked for use by or provided to any resident. The services and supplies shall be included in the provider’s cost report.

(44) “Sale-leaseback” means a transaction in which an owner sells a facility to a related or non-related purchaser and then leases the facility from the new owner to operate as the provider.

(45) “Severe and persistent mental illness” means mental illness as defined in this regulation, but shall include both of the following additional requirements:

(A) The individual meets one of the following criteria:

(i) Has undergone psychiatric treatment more intensive than what could have been provided through outpatient care more than once in a lifetime; or

(ii) has experienced a single episode of continuous, structured, supportive residential care other

than hospitalization for a duration of at least two months.

(B) The individual meets at least two of the following criteria, on a continuing or intermittent basis, for at least two years:

(i) Is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history;

(ii) requires public financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help;

(iii) shows a severe inability to establish or maintain a personal social support system;

(iv) requires help in basic living skills; or

(v) exhibits inappropriate social behavior that results in a need for intervention by the mental health or judicial system.

(46) "Specialized mental health rehabilitation services" means one of the specialized rehabilitative services that provide ongoing treatment for mental health problems and that are aimed at attaining or maintaining the highest level of mental and psychosocial well-being. The specialized rehabilitative services shall include the following:

(A) Crisis intervention services;

(B) drug therapy or monitoring of drug therapy;

(C) training in medication management;

(D) structured socialization activities to diminish tendencies toward isolation and withdrawal;

(E) development and maintenance of necessary daily living skills, including grooming, personal hygiene, nutrition, health and mental health education, and money management; and

(F) maintenance and development of appropriate personal support networks.

(47) "Specialized services" means inpatient psychiatric care for the treatment of an acute episode of mental illness.

(48) "State licensing agency" means the department of health and environment for hospital-based nursing facilities and the department on aging for all other nursing facilities.

(49) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital bed or nursing facility bed.

(50) "Twenty-four-hour nursing care" means the provision of 24-hour licensed nursing services with the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(51) "Working trial balance" means a list of the account balances in general ledger order that was used in completing the cost report.

(b) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended May 1, 2002; amended May 1, 2005.)

**30-10-1b. Nursing facility program providers.** (a) The nursing facility program providers shall include the following types of care facilities:

(1) Nursing facilities; and

(2) nursing facilities for mental health, which shall have been operating in accordance with a provider agreement with the agency on June 30, 1994.

(b) Each provider shall meet the following requirements with regard to any change in the structure of the business entities involved in the ownership, operation, or management of the nursing facility:

(1) The current provider or prospective provider shall notify the agency in writing by certified mail of a proposed change of providers at least 60 days in advance of the closing transaction date. If the current or prospective provider fails to submit a timely notification, the new provider shall assume responsibility for any overpayment made to the previous provider before the transfer. Failure to submit timely notification shall not release the previous provider from responsibility for the overpayment.

(2) Before the dissolution of the provider business entity or a transaction involving a change of ownership of the nursing facility or the change of lessee of the nursing facility, the provider shall notify the agency in writing at least 60 days before the change. If the provider fails to submit a timely notification, the new provider shall assume responsibility for any overpayment made to the previous provider before the transfer. Failure to submit timely notification shall not release the previous provider from responsibility for the overpayment. Other overpayment recovery terms may be expressly agreed to in writing by the secretary.

(3) The provider shall submit an application to

be a provider of services to the agency for any addition or substitution to a partnership or any change of provider resulting in a completely new partnership. An application shall not be required when a partnership is dissolved and at least one member of the partnership remains as the provider of services.

(4) If a sole proprietor that is not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. The new owner shall submit an application to be a provider of services to the agency.

(5) Each consolidation of two or more unrelated corporations that creates a new corporate entity through an arm's-length transaction shall constitute a change of provider. The new corporate entity resulting from the consolidation shall submit an application to be a provider of services to the agency.

(6) Each change or creation of a new lessee acting as a provider of services shall constitute a change of provider. The new lessee shall submit an application to be a provider of services to the agency.

(7) Each provider shall submit documentation of any other change in the ownership or corporate structure of the business entities involved in the ownership, operation, or management of the nursing facility.

(c) Only a change in or creation of a provider of service through a bona fide transaction shall be recognized as resulting in a new provider. The following situations shall not be recognized as resulting in a change of provider, and the facility shall be treated as an ongoing entity:

(1) A transfer of participating provider corporate stock;

(2) a merger of one or more corporations with the participating provider corporation surviving;

(3) the purchase of the facility by the lessee;

(4) the change or creation of a sublessee acting as the provider of services;

(5) the creation of a new lessee that is related to the old owner of the facility;

(6) the creation of a new lessee acting as the provider of services that is related to the old lessee;

(7) the change or creation of a management firm acting as the provider of services; and

(8) the takeover of the lessee's operations by an owner of the facility.

(d) Each new provider shall be subject to a cer-

tification survey by the state licensing agency. If certified, the period of certification shall be established by the state licensing agency.

(e) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended May 1, 2005.)

**30-10-1c. Provider agreement.** (a) As a prerequisite for participation in the medicaid/medikan program as a nursing facility provider, the owner of the real and personal property used to provide the nursing facility services or the lessee of such real and personal property shall enter into a provider agreement with the agency on forms prescribed by the secretary.

(b) Only parties signing a provider agreement shall have rights to enforcement of the agreement. The effective date of this regulation shall be January 1, 1994. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1982; amended May 1, 1986; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan 3, 1994.)

**30-10-1d. Inadequate care.** (a) If the agency determines that inadequate care is being provided to a recipient or that a recipient's rights are being violated, payment to the nursing facility may be terminated or suspended.

(b) If the agency determines that a nursing facility has not corrected deficiencies that significantly and adversely affect the health, safety, nutrition, or sanitation of the nursing facility residents, payments for new admissions shall be denied and future payments for all recipients shall be withheld until the agency determines that the deficiencies have been corrected.

(c) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended, T-87-43, Dec. 19, 1986; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Jan. 3, 1994; amended May 1, 2005.)

**30-10-1e.** (Authorized by and implement-

ing K.S.A. 1983 Supp. 39-708c; effective May 1, 1984; revoked May 1, 1986.)

**30-10-1f. Private pay wings.** As a prerequisite for participation in the medicaid/medikan program, a nursing facility shall not develop private pay wings or segregate medicaid/medikan residents to separate areas of the nursing facility. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991.)

**30-10-2. Standards for participation; nursing facilities and nursing facilities for mental health.** (a) As a prerequisite for participation in the Kansas medical assistance program as a provider of nursing facility services, each nursing facility and each nursing facility for mental health shall perform the following:

- (1) Provide nursing services;
- (2) meet the requirements of Title IV, subtitle C, part 2 of the federal omnibus budget reconciliation act of 1987, effective October 1, 1990, which is adopted by reference;
- (3) be certified for participation in the program for all licensed beds by the Kansas department of health and environment or the federal department of health and human services;
- (4) have been operating under a provider agreement with the agency on June 30, 1994 if the certification is for a nursing facility for mental health;
- (5) submit an application for participation in the program on forms prescribed by the secretary of social and rehabilitation services;
- (6) update provided information as required by the application forms;
- (7) furnish and allow inspection of any information that the agency, its designee, or the United States department of health and human services may request in order to assure proper payment by the Kansas medical assistance program;
- (8) inform all new residents of the availability of a potential eligibility assessment under the federal spousal impoverishment law. This assessment shall be completed by the agency or a local agency office;
- (9) ensure that before a nonemergency admission of each resident, state-mandated preadmission and referral services have been completed by the Kansas department on aging;

(10) provide nonemergency transportation; and

(11) submit to the agency a copy of the resident assessment form for each resident as follows:

(A) Each nursing facility shall complete a resident assessment form no later than 14 days after admission, no later than 14 days after a significant change in the resident's physical or mental condition, and in no case less often than once every 12 months. Each nursing facility shall conduct a review by completing the resident assessment form no less often than once every three months. Assessments shall be used to monitor the appropriate level of care.

(B) Each nursing facility shall submit resident assessment forms, including the tracking documents, within seven days of completion. Each resident assessment form shall be sent to the state data base by electronic transmission. A resident assessment form shall be considered timely submitted upon the receipt of the electronic submission.

(C) Penalty for nonsubmission of accurate and timely assessment. If 10 percent or more of a nursing facility's assessments are not completed and submitted as required, all further payments to the provider shall be suspended until the forms have been completed and submitted electronically. Thirty days before suspending payment to a provider, written notice stating the agency's intent to suspend payments shall be sent by the agency to the provider. This notice shall explain the basis for the agency's determination and shall explain the necessary corrective action that must be taken before payments are reinstated.

(D) Any assessment that cannot be classified shall be assigned to the lowest classification group.

(b) This regulation shall be effective on and after May 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective, E-74-43, Aug. 16, 1974; effective, E-74-63, Dec. 4, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1982; amended May 1, 1983; amended May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended July 1,



1998; amended Jan. 1, 1999; amended May 1, 2002.)

**30-10-3.** This rule and regulation shall expire on November 2, 1992. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, E-74-43, Aug. 16, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; revoked Nov. 2, 1992.)

**30-10-4.** This rule and regulation shall expire on November 1, 1992. (Authorized by and implementing K.S.A. 39-708c; effective, E-74-43, Aug. 16, 1974; effective May 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1982; amended May 1, 1983; amended May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990; revoked Nov. 2, 1992.)

**30-10-5.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-74-59, Oct. 24, 1974; effective May 1, 1975; amended May 1, 1976; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-10-6. Admission procedure.** (a) The physical, emotional, social, and cognitive status of each individual, including any individual from out of state, who is seeking admission to a nursing facility or a nursing facility for mental health providing care under title XIX of the federal social security act shall be assessed to determine the need for care and the appropriateness of services in accordance with K.S.A. 39-968 and amendments thereto.

(b) Nursing facility services and nursing facility for mental health services shall be provided pursuant to title IV, subtitle C, part 2, pp. 190-230, of the federal omnibus budget reconciliation act of 1987, effective October 1, 1990, which is adopted by reference in K.A.R. 30-10-2. Each resident shall receive a comprehensive medical eval-

uation and an explicit recommendation by the physician concerning the level of care needed.

(c) A nursing facility shall not require a private-paying resident to remain in a private-pay status for any period of time after the resident becomes eligible for medicaid/medikan.

(d) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective, E-74-59, Oct. 24, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 4, 1993; amended March 1, 1995; amended July 1, 2002.)

**30-10-7. Screening, evaluation, reevaluation, and referral for nursing facilities.** (a) In accordance with K.S.A. 39-968 and amendments thereto, each individual seeking admission to a nursing facility or nursing facility for mental health providing care under title XIX of the federal social security act, or seeking referral to home- and community-based services (HCBS), shall receive a preadmission assessment, evaluation, and referral to all available community resources, including nursing facilities, before admission.

(b) Each individual choosing to enter a nursing facility following a preadmission assessment identifying no need for nursing facility placement shall do so as a private-paying resident. Medicaid/medikan shall not participate in the cost of care unless and until a preadmission assessment determines that there is a need for nursing facility placement.

(c) Continued eligibility for services at a nursing facility shall be based on each resident's level of care needs as determined through quarterly reassessments. When the reassessment indicates that the resident's level of care needs no longer meet level of care criteria, the resident shall be considered to be in "resident status review." Payment for services shall continue until the authorized case manager indicates that more appropriate and less intensive services are available that meet the resident's health, safety, and social needs.

(d) Each individual admitted to a nursing facility for mental health shall be evaluated at least

annually upon the anniversary of admission, and at any other time there may have been a significant change in the resident's mental condition. This evaluation shall be made under the supervision of a qualified mental health professional employed by a participating community mental health center, as defined in K.S.A. 59-2946 and amendments thereto, using the screening tool that may be designated by the secretary, to determine whether it is appropriate for that individual to remain in a nursing facility for mental health. Any state-funded individual for whom it is determined that remaining in the facility is inappropriate may be required to have prepared a plan for that individual's transfer to appropriate care.

(e) This regulation shall be effective on and after May 1, 2002. (Authorized by and implementing K.S.A. 39-708c and K.S.A. 39-785; effective, E-74-59, Oct. 24, 1974; effective May 1, 1975; amended May 1, 1976; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-28, Nov. 14, 1984; amended May 1, 1985; amended May 1, 1986; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1991; amended Jan. 4, 1993; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 30, 1994; amended March 1, 1995; amended Jan. 1, 1997; amended May 1, 2002.)

**30-10-8.** This rule and regulation shall expire on November 2, 1992. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, E-74-59, Oct. 24, 1974; effective May 1, 1975; amended May 1, 1976; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; revoked Nov. 2, 1992.)

**30-10-9.** This rule and regulation shall expire on January 30, 1991. (Authorized by and implementing K.S.A. 39-708c; effective, E-74-43, Aug. 16, 1974; effective, E-74-44, Aug. 28, 1974; effective, E-74-63, Dec. 4, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978;

amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked, T-30-10-1-90, Oct. 1, 1990; revoked Jan. 30, 1991.)

**30-10-10.** (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-74-43, Aug. 16, 1974; effective May 1, 1975; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

**30-10-11. Personal needs fund.** (a) At the time of admission, each nursing facility provider shall furnish each resident and the resident's representative, if any, with a written statement that meets the following requirements:

(1) Lists all services provided by the provider, distinguishing between those services included in the provider's per diem rate and those services not included in the provider's per diem rate that can be charged to the resident's personal needs fund;

(2) states that there is no obligation for the resident to deposit funds with the provider;

(3) describes each resident's right to select one of the following alternatives for managing the personal needs fund:

(A) The resident or the resident's legal guardian, if any, may receive, retain, and manage the resident's personal needs fund;

(B) the resident may apply to the social security administration to have a representative payee designated for federal or state benefits to which the resident may be entitled; or

(C) except when paragraph (B) of this subsection applies, the resident may designate, in writing, another person to act for the purpose of managing the resident's personal needs fund;

(4) states that any charge for management of a resident's personal needs fund is included in the provider's per diem rate;

(5) states that any late fees, interest, or finance charges shall not be charged to the resident's personal needs fund for late payment of the resident liability;

(6) states that the provider is required to accept a resident's personal needs fund to hold, safeguard, and provide an accounting for it, upon the written authorization of the resident or represen-

tative, or upon appointment of the provider as the resident's representative payee; and

(7) states that, if the resident becomes incapable of managing the personal needs fund and does not have a representative, the provider shall be required to arrange for the management of the resident's personal funds as provided in subsection (j).

(b)(1) The provider shall, upon written authorization by the resident, accept responsibility for holding, safeguarding, and accounting for the resident's personal needs fund. The provider may make arrangements with a federally insured or state-insured banking institution to provide these services. However, the responsibility for the quality and accuracy of compliance with the requirements of this regulation shall remain with the provider. The provider shall not charge the resident for these services. Routine bank service charges shall be included in the provider's per diem rate and shall not be charged to the resident. Overdraft charges and other bank penalties shall not be allowable.

(2) The provider shall maintain current, written, and individual records of all financial transactions involving each resident's personal needs fund for which the provider has accepted responsibility. The records shall include at least the following:

- (A) The resident's name;
- (B) an identification of the resident's representative, if any;
- (C) the admission date of the resident;
- (D) the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction;
- (E) receipts indicating the purpose for which any withdrawn funds were spent; and
- (F) the resident's earned interest, if any.

(3) The provider shall provide to each resident reasonable access to the resident's own financial records.

(4) The provider shall provide a written statement, at least quarterly, to each resident or representative. The statement shall include at least the following:

- (A) The balance at the beginning of the statement period;
- (B) total deposits and withdrawals;
- (C) the interest earned, if any; and
- (D) the ending balance.

(c) Commingling prohibited. The provider

shall keep any funds received from a resident for holding, safeguarding, and accounting separate from the provider's operating funds, activity funds, and resident council funds and from the funds of any person other than another resident in that facility.

(d) Types of accounts; distribution of interest.

(1) Petty cash. The provider may keep up to \$50.00 of a resident's money in a non-interest-bearing account or petty cash fund.

(2) Interest-bearing accounts. The provider shall, within 15 days of receipt of the money, deposit in an interest-bearing account any funds in excess of \$50.00 from an individual resident. The account may be an individual account for the resident or may be pooled with other resident accounts. If a pooled account is used, each resident shall be individually identified on the provider's books. The account shall be in a form that clearly indicates that the provider does not have an ownership interest in the funds. The account shall be insured under federal or state law.

(3) The interest earned on any pooled interest-bearing account shall be distributed without reductions in one of the following ways, at the election of the provider:

(A) Prorated to each resident on an actual interest-earned basis; or

(B) prorated to each resident on the basis of the resident's end-of-quarter balance.

(e) The provider shall provide the residents with reasonable access to their personal needs funds. The provider shall, upon request or upon the resident's transfer or discharge, return to the resident, the legal guardian, or the representative payee the balance of the resident's personal needs fund for which the provider has accepted responsibility, and any funds maintained in a petty cash fund. When a resident's personal needs fund for which the provider has accepted responsibility is deposited in an account outside the facility, the provider, upon request or upon the resident's transfer or discharge, shall within 15 business days return to the resident, the legal guardian, or the representative payee the balance of those funds.

(f) If a provider is a resident's representative payee and directly receives monthly benefits to which the resident is entitled, the provider shall fulfill all of its legal duties as representative payee.

(g) Duties on change of provider.

(1) Upon change of providers, the former provider shall furnish the new provider with a written account of each resident's personal needs fund to

be transferred and shall obtain a written receipt for those funds from the new provider.

(2) The provider shall give each resident's representative a written accounting of any personal needs fund held by the provider before any change of provider occurs.

(3) If a disagreement arises regarding the accounting provided by the former provider or the new provider, the resident shall retain all rights and remedies provided under state law.

(h) Upon the death of a resident who is a recipient of medical assistance, the provider shall take the following actions:

(1) The provider shall in good faith determine or attempt to determine within 30 days from the date of death whether there is a surviving spouse, minor or disabled children, or an executor or administrator of the resident's estate.

(A) If there is an executor or an administrator, the provider shall contact the executor or administrator and convey the monies in the personal needs fund as the executor or administrator directs.

(B) If there is no executor or administrator but there is a surviving spouse, the provider shall contact the surviving spouse and convey the monies in the personal needs fund as that surviving spouse directs.

(C) If there is no executor or administrator or surviving spouse, but there are minor or disabled children, the provider shall contact the guardian or personal representative of the minor or disabled children or, if appropriate, the adult disabled children and convey the monies in the personal needs fund as that person directs.

(D) If there is no surviving spouse, minor or disabled children, or executor or administrator, the provider shall convey within 30 days the personal needs fund to the estate recovery unit, which shall be responsible for notifying the appropriate court or personal representative of the receipt of the monies from the personal needs fund of the resident.

(2) The provider shall provide the estate recovery unit with a written accounting of the personal needs fund within 30 days of the resident's death. The accounting shall also be provided to the executor or administrator of the resident's estate, if any; the surviving spouse, if any; the guardian or representative of the surviving minor or disabled children, if any; the personal representative of the resident, if any; and the resident's next of kin.

(i) The provider shall purchase a surety bond and submit a report on forms designated by the state licensing agency. The provider shall give assurance of financial security in an amount equal to or greater than the sum of all residents' funds managed by the provider at any time.

(j) If a resident is incapable of managing the resident's personal needs fund, has no representative, and is eligible for supplemental security income (SSI), the provider shall notify the local office of the social security administration and request that a representative be appointed for that resident. If the resident is not eligible for SSI, the provider shall refer the resident to the local agency office, or the provider shall serve as a temporary representative payee for the resident until the actual appointment of a guardian, conservator, or representative payee.

(k) Resident property records.

(1) The provider shall maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the provider by the resident.

(2) The property record shall be available to the resident and the resident's representative.

(l) Providers shall keep all personal needs funds in the state of Kansas.

(m) Personal needs funds shall not be turned over to any person other than a duly accredited agent or guardian of the resident. With the consent of the resident, if the resident is able and willing to give consent, the administrator shall turn over a resident's personal needs fund to a designated person to purchase a particular item. However, a signed, itemized, and dated receipt shall be required for deposit in the resident's personal needs fund envelope or another type of file.

(n) A receipt for each transaction shall be signed by the resident, legal guardian, conservator, or responsible party. Recognizing that a legal guardian, conservator, or responsible party is not necessarily available at the time each transaction is made for or on behalf of a resident, the provider shall have a procedure that includes a provision for receipts to be signed on at least a quarterly basis.

(o) The provider shall provide and maintain a system of accounting for expenditures from the resident's personal needs fund. This system shall follow generally accepted accounting principles and shall be subject to audit by representatives of the agency.

(p) Suspension of program payments may be



made if the agency determines that any provider is not in compliance with the regulations governing personal needs funds. Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider stating the agency's intent to suspend payments. The notice shall explain the basis for the agency's determination and shall explain the necessary corrective action that shall be completed before payments are released.

(q) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective, E-74-43, Aug. 16, 1974; effective, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Jan. 4, 1993; amended Jan. 3, 1994; amended July 1, 2002; amended May 1, 2005.)

**30-10-12.** (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, E-74-43, Aug. 16, 1974; effective, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-25, Aug. 27, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; revoked May 1, 1985.)

**30-10-13.** (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended, T-85-34, Dec. 19, 1984; revoked May 1, 1985.)

**30-10-14.** (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Aug. 14, 1998; revoked Aug. 15, 2003.)

**30-10-15a.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended July 1, 2002; amended Aug. 15, 2003; revoked Sept. 19, 2008.)

**30-10-15b.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 1, 1999; amended July 1, 2002; revoked Sept. 19, 2008.)

**30-10-16.** This rule and regulation shall expire on July 1, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective May 1, 1987; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; revoked July 1, 1991.)

**30-10-17.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended July 1, 2002; amended Dec. 31, 2002; amended, T-30-5-30-03, July 1, 2003; amended July 25, 2003; amended May 1, 2005; revoked Sept. 19, 2008.)

**30-10-18.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended

Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1999; amended June 28, 2002; amended Dec. 31, 2002; amended, T-30-5-30-03, July 1, 2003; amended July 25, 2003; amended, T-30-12-29-04, Dec. 29, 2004; amended April 1, 2005; revoked Sept. 19, 2008.)

**30-10-19. Rates; effective dates.** (a) Effective date of per diem rates for ongoing providers filing calendar year cost reports. The effective date of a new rate that is based on information and data in the nursing facility cost report for the calendar year shall be July 1.

(b) Effective date of the per diem rate for a new provider operating on the rate from cost data of the previous provider.

(1) The effective date of the per diem rate for a new provider shall be the date of certification by the state licensing agency.

(2) The effective date of the per diem rate based on the first historical cost report filed in accordance with K.A.R. 30-10-17 shall be the first day of the 25th month of operation. Any rates paid after the effective date of the rate based on the first historical cost report shall be adjusted to the new rate from the historical cost report.

(c) Effective date of the per diem rate from a projected cost report.

(1) The effective date of the per diem rate based on a projected cost report for a new provider, as set forth in K.A.R. 30-10-18 (c) and (e), shall be the date of certification by the state licensing agency.

(2) The interim rate determined from the projected cost report filed by the provider shall be established by the agency and given to the fiscal agent on or by the first day of the third month after the receipt of a complete and workable cost report.

(3) The effective date of the final rate, determined after an audit of the historical cost report filed for the projected cost report period, shall be the date of certification by the state licensing agency.

(4) The second effective date for a provider filing an historic cost report covering a projected cost report period shall be the first day of the month following the last day of the period covered by the report, which is the date that the inflation factor is applied in determining prospective rates.

(d) Each provider shall receive an adjusted rate quarterly if there are changes in the facility's med-

icaid case mix index as described in K.A.R. 30-10-18.

(e) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended July 1, 2002; amended, T-30-5-30-03, July 1, 2003; amended July 25, 2003; amended May 1, 2005.)

**30-10-20. Payment of claims.** (a) Payment to participating providers. Each participating provider shall be paid, at least monthly, a per diem rate for nursing facility services, excluding resident liability, rendered to eligible residents if all of the following conditions are met:

(1) The agency is billed on the paper claim form or electronic claim submission furnished by the contractor serving as the fiscal agent for the medicaid/medikan program.

(2) The paper claim form or electronic claim submission is verified by the administrator of the facility or a designated key staff member.

(3) The claim is filed no more than 12 months after the time the services were rendered pursuant to K.S.A. 39-708a, and amendments thereto.

(4) The claim does not include services for the date of discharge.

(b) Resident's liability. The resident's liability for services shall be the amount determined by the local agency office in which a medicaid/medikan resident or the resident's agent applies for care. The resident's liability begins on the first day of each month and shall be applied in full before any liability incurred by the medicaid/medikan program. The unexpended portion of the resident's liability payment shall be refunded to the resident or to the resident's agent if the resident dies or otherwise permanently leaves the facility. Providers shall not charge fees or finance charges related to late payment of resident liability.

(c) The payment of claims may be suspended if there has been an identified overpayment and the provider is financially insolvent.

(d) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended

Nov. 2, 1992; amended April 1, 1995; amended May 1, 2005.)

**30-10-21. Reserve days.** (a) Payment shall be available for nursing facility residents, excluding those on planned temporary stays, for days for which it is necessary to reserve a bed in a nursing facility (NF) or nursing facility for mental health (NF-MH) when the resident is absent for any of the following reasons:

- (1) Admission to a hospital for acute conditions;
- (2) therapeutically indicated home visits with relatives and friends; or
- (3) participation in any state-approved therapeutic or rehabilitative program.

(b) In order for payment to be available, the following requirements shall be met when a bed is reserved in a nursing facility or nursing facility for mental health because of a resident's hospitalization for acute conditions:

(1) The period of hospitalization shall not exceed either of the following limits:

(A) 10 days for each single hospital stay for an acute condition; or

(B) 21 days for residents from a nursing facility for mental health for each admission to a state mental institution or admission to a psychiatric ward in any of the following:

- (i) A general hospital;
- (ii) a private psychiatric hospital; or
- (iii) a veterans administration medical center.

(2) The resident shall intend to return to the same facility after hospitalization.

(3) The hospital shall provide a discharge plan for the resident.

(4) Reimbursement shall not be made to reserve a bed in a swing bed hospital if a nursing facility will be reimbursed for the same day to reserve a bed for the resident's return from the hospital.

(c) The resident's plan of care shall provide for the non-hospital-related absence.

(1) Payment for non-hospital-related reserve days for eligible residents in nursing facilities for mental health shall not exceed 21 days per calendar year, including travel. If additional days are required to obtain or retain employment, participate in a job readiness training program, or alleviate a severe hardship, the requesting party shall send a request for additional days and supporting documentation to the fiscal agent for approval or disapproval.

(2) Payment for non-hospital-related reserve days for all eligible residents in nursing facilities shall not exceed 18 days per calendar year, including travel. If additional days are required to alleviate a severe hardship, the requesting party shall send a request for additional days and supporting documentation to the fiscal agent for approval or disapproval.

(d) This regulation shall not prohibit any resident from leaving a facility if the resident so desires.

(e) Payments made for unauthorized reserve days shall be reclaimed by the agency.

(f) (1) Before any routine absence by residents, the provider shall notify the local agency office.

(2) In case of emergency admission to a hospital, the provider shall notify the local agency office not later than five working days following admission.

(g) Payment for reserve days shall be approved except when the absence is longer than 10 hospital days for NF or NF-MH residents or 21 hospital days for NF-MH residents who enter either of the following:

- (1) A state mental hospital; or
- (2) a psychiatric ward in any of the following:
  - (A) A general hospital;
  - (B) a private psychiatric hospital; or
  - (C) a veterans administration medical center.

(Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1996; amended Oct. 1, 2000; amended July 1, 2002; amended Aug. 15, 2003.)

**30-10-22.** This rule and regulation shall expire on January 30, 1991. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1985; revoked, T-30-10-1-90, Oct. 1, 1990; revoked Jan. 30, 1991.)

**30-10-23a.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1988; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended July 1, 2002; amended Dec. 31, 2002; amended May 1, 2005; revoked Sept. 19, 2008.)

**30-10-23b.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Dec. 29, 1995; amended Aug. 15, 2003; amended May 1, 2005; revoked Sept. 19, 2008.)

**30-10-23c. Revenues.** A statement of revenue shall be required as part of the cost report forms. (a) Revenue shall be reported in accordance with general accounting rules as recorded in the accounting records of the facility and as required in the detailed revenue schedule in the uniform cost report.

(b) The cost of non-covered services provided to residents shall be deducted from the related expense item. The net expense shall not be less than zero.

(c) Revenue received for a service that is not related to resident care shall be used to offset the cost of providing that service, if the cost incurred cannot be determined or is not furnished to the agency by the provider. The cost report line item which includes the non-resident related costs shall not be less than zero. Miscellaneous revenue with insufficient explanation in the cost report shall be offset.

(d) Expense recoveries credited to expense accounts shall not be reclassified as revenue to increase the costs reported in order to qualify for a higher rate. The effective date of this regulation shall be November 2, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by 1992 SB 182, Sec. 5; effective May 1, 1985; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992.)

**30-10-24. Compensation of owners, related parties, and administrators.** (a) Non-working owners and related parties. Remunerations paid to non-working owners or other related parties, as defined in K.A.R. 30-10-1a, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-resident-related expense section of the cost report.

(b) Services related to resident care.

(1) If owners with five percent or more ownership interest or related parties actually perform

a necessary function directly contributing to resident care, a reasonable amount shall be allowed for such resident care activity. The reasonable amount allowed shall be the lesser of the following:

(A) The reasonable cost that would have been incurred to pay a non-owner employee to perform the resident-related services actually performed by owners or other related parties, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed until the subsequent cost report is filed; or

(B) the amount of cash and other assets actually withdrawn by the owner or related parties.

(2) The resident-related functions shall be limited to those functions that are normally performed by non-owner employees common to the industry and for which cost data is available. The job titles for administrative and supervisory duties performed by an owner or related party shall be limited to the work activities included in the schedule of the owner or related party salary limitations.

(3) The salary limit shall be prorated in accordance with subsection (c) of this regulation. The limitation shall not exceed the highest salary limit on the civil-service-based chart.

(4) The owner or related party shall be professionally qualified for those functions performed that require licensure or certification.

(5) Cash and other assets actually withdrawn shall include only those amounts or items actually paid or transferred during the cost reporting period in which the services were rendered and reported to the internal revenue service.

(6) The owner or related party shall pay any liabilities established in cash within 75 days after the end of the accounting period.

(c) Allocation of owner or related party total work time for resident-related functions. When any owner or related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the compensation limit shall be prorated. The time spent on each function within a facility or within all facilities in which the owner or related party has an ownership or management interest shall be prorated separately by function, but shall not exceed 100 percent of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.



(d) Reporting owner or related party compensation on cost report. The provider shall report owner or related party compensation on the owner compensation line in the appropriate cost center for the work activity involved. Any compensation paid to employees who have an ownership interest of five percent or more, including employees at the central office of a chain organization, shall be deemed owner compensation. Providers with any professionally qualified owner or related party employees performing duties other than those for which they are professionally qualified shall report the cost for these duties in the operating cost center.

(e) Owner-administrator compensation limitation.

(1) Reasonable limits shall be determined by the agency for owner-administrator compensation based upon the current civil service salary schedule.

(2) This limitation shall apply to the salaries of each administrator and coadministrator of that facility and to owner compensation reported in the operating cost center. This limitation shall apply to the salaries of the administrator and coadministrator, regardless of whether they have any ownership interest in the business entity.

(3) Each salary in excess of the owner or related party limitations determined in accordance with subsections (b) and (c) of this regulation shall be transferred to the owner compensation line in the operating cost center and shall be subject to the owner-administrator compensation limitation. The provider shall include all owner-administrator compensation in excess of the limitation in the administrative costs used to compute the incentive factor.

(f) Management consultant fees. Fees for consulting services provided by owners and related parties shall be deemed owner's compensation subject to the owner-administrator compensation limit. The provider shall report fees on the owner compensation line in the operating cost center if the actual cost of the service is not submitted with the adult care home financial and statistical report:

(1) Related parties as defined in K.A.R. 30-10-1a;

(2) current owners of the provider agreement and operators of the facility;

(3) current owners of the facility in a lessor-tenant relationship;

(4) management consulting firms owned and

operated by former business associates of the current owners in this and other states;

(5) owners who sell and enter into management contracts with the new owner to operate the facility; and

(6) accountants, lawyers, and other professional people who have common ownership interests in other facilities, in this or other states, with the owners of the facility from which the consulting fee is received.

(g) Costs not related to resident care. An allowance shall not be made for costs related to investigation of investment opportunities, travel, entertainment, goodwill, or administrative or managerial activities performed by owners or other related parties that are not directly related to resident care.

(h) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Dec. 29, 1995; amended July 1, 2002.)

**30-10-25.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended July 1, 2002; revoked Sept. 19, 2008.)

**30-10-26.** (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Jan. 1, 1999; revoked Sept. 19, 2008.)

**30-10-27.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Dec. 29, 1995; amended July 1, 2002; revoked Sept. 19, 2008.)

**30-10-28. Resident days.** (a) Calculation of resident days.

(1) "Resident day" shall have the meaning set forth in K.A.R. 30-10-1a.

(2) If both admission and discharge occur on

the same day, that day shall be considered to be a day of admission and shall count as one resident day.

(3) If the provider does not make refunds on behalf of a resident for unused days in case of death or discharge, and if the bed is available and actually used by another resident, these unused days shall not be counted as a resident day.

(4) Any bed days paid for by the resident, or any other party on behalf of the resident, before an admission date shall not be counted as a resident day.

(5) The total resident days for the cost report period shall be precise and documented; an estimate of the days of care provided shall not be acceptable.

(6) In order to facilitate accurate and uniform reporting of resident days, the accumulated method format set forth in data specifications in diskettes furnished by the agency shall be used for all residents beginning January 1, 1999. The monthly reporting, using the diskette, shall be submitted to the agency as supportive documentation for the resident days shown on the cost report forms and shall be submitted at the time the cost report and required documents are submitted to the agency. Monthly census summaries shall include reporting for nursing facility or nursing facility-mental health, other residential days with shared nursing facility or nursing facility-mental health costs, and day care hours. Each provider shall keep these monthly records for each resident, whether a Kansas medical assistance program recipient or a non-recipient. If the provider fails to keep accurate records of resident days in accordance with the accumulated method format, the assumed occupancy rate shall be 100 percent.

(7) The provider shall report the total number of Kansas medical assistance program resident days in addition to the total resident days on the uniform cost report form.

(8) The provider shall report the total number of other residential days with shared nursing facility or nursing facility-mental health costs on the uniform cost report form.

(b) Respite care days shall be counted as resident days and reported on the monthly census forms.

(c) Day care and day treatment shall be counted as one resident day for 18 hours of service. The total hours of service provided for all res-

idents during the cost reporting year shall be divided by 18 hours to convert to resident days.

(d) This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1985; amended May 1, 1987; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Jan. 1, 1999.)

**30-10-29.** (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective, T-86-42, Dec. 18, 1985; effective, T-87-5, May 1, 1986; effective May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Dec. 29, 1995; revoked June 28, 2002.)

**30-10-30.** This rule and regulation shall expire on May 1, 1991. (Authorized by K.S.A. 39-708c; implementing 1989 HB 2028; effective Jan. 2, 1990; revoked May 1, 1991.)

**30-10-31 to 30-10-199. Reserved.**

**30-10-200.** (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Oct. 1, 1991; amended April 1, 1992; revoked Sept. 19, 2008.)

**30-10-201. Intermediate care facilities for mentally retarded.** (a) Change of provider.

(1) The current provider or prospective provider shall notify the agency of a proposed change of providers at least 60 days in advance of the closing transaction date. Failure to submit a timely notification shall result in the new provider assuming responsibility for any overpayment made to the previous provider before the transfer. This shall not release the previous provider of responsibility for such overpayment.

(2) Before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the agency shall be notified in writing concerning the change at least 60 days before the change. Failure to submit a timely notification shall result in the new provider assuming responsibility for any overpayment made to the previous provider

before the transfer. This shall not release the previous provider of responsibility for such overpayment. The secretary may expressly agree in writing to other overpayment recovery terms.

(3) Any partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the provider of services. Any addition or substitution to a partnership or any change of provider resulting in a completely new partnership shall require that an application to be a provider of services be submitted to the agency.

(4) If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of services shall be submitted to the agency.

(5) Transfer of participating provider corporate stock shall not in itself constitute a change of provider. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of provider. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of provider and an application to be a provider of services shall be submitted to the agency.

(6) The change of or a creation of a new lessee, acting as a provider of services, shall constitute a change of provider. An application to be a provider of services shall be submitted to the agency. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in provider.

(b) Each new provider shall be subject to a certification survey by the department of health and environment and, if certified, the period of certification shall be as established by the Kansas department of health and environment. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

**30-10-202. ICF-MR provider agreement.** As a prerequisite for participation in the medicaid/medikan program as an ICF-MR provider, the owner or lessee shall enter into a provider agreement with the agency on forms prescribed by the secretary. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended

by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

**30-10-203. ICF-MR inadequate care.**

(a) When the agency determines that inadequate care is being provided to a client, payment to the ICF-MR for the client may be terminated.

(b) When the agency receives confirmation from the Kansas department of health and environment that an ICF-MR has not corrected deficiencies which significantly and adversely affect the health, safety, nutrition or sanitation of ICF-MR clients, payments for new admissions shall be denied and future payments for all clients shall be withheld until confirmation that the deficiencies have been corrected. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

**30-10-204. ICF-MR standards for participation; intermediate care facility for the mentally retarded or clients with related conditions.**

As a prerequisite for participation in the medicaid/medikan program as a provider of intermediate care facility services for the mentally retarded or clients with related conditions, each ICF-MR shall: (a) Meet the requirements of 42 CFR 442, subparts A, B, C and E, effective October 3, 1988, which is adopted by reference, and 42 CFR 483, subpart D, effective October 3, 1988, which is adopted by reference; and

(b) be certified for participation in the program by the Kansas department of health and environment. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

**30-10-205. ICF-MR admission procedure.**

(a) Admission procedure for ICF's-MR shall be pursuant to 42 CFR 483.440, effective October 3, 1988, which is adopted by reference.

(b) An ICF-MR shall not require a private-paying client to remain in a private-pay status for any period of time after the client becomes eligible for medicaid/medikan.

(c) Each client shall be screened and found eligible for services before the client is admitted in the medicaid/medikan program. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.A.R. 39-

708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

**30-10-206. ICF-MR certification and recertification by physicians.** (a) Certification. At the time of admission to an ICF-MR or at the time any ICF-MR client applies for medical assistance under the medicaid/medikan program, a physician or physician extender shall certify that the services must be given on an inpatient basis. Services shall be furnished under a plan established by the physician or physician extender before authorization of payment. Before reimbursement is approved, a screening team designated by the secretary shall review the physician's or physician extender's certification and shall certify that services in an ICF-MR are the most appropriate services available for the individual. The certification of need shall become part of the individual's medical record. The date of certification shall be the date the case is approved for payment and the certification is signed.

(b) Recertification.

(1) Each ICF-MR shall be responsible for obtaining a physician's or physician extender's recertification for each client.

(2) The recertification shall be included in the client's medical record. Recertification statements may be entered on or included with forms, notes, or other records a physician or physician extender normally signs in caring for a client. The statement shall be authenticated by the actual date and signature of the physician or physician extender.

(c) If the appropriate professional refuses to certify or recertify because, in the professional's opinion, the client does not require ICF-MR care on a continuing basis, the services shall not be covered. The reason for the refusal to certify or recertify shall be documented in the client's records. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

**30-10-207. ICF-MR inspection of care and utilization review.** (a) The inspection of care team from the Kansas department of health and environment shall conduct an inspection of care and utilization review of each medicaid/medikan client in all intermediate care facilities for the mentally retarded certified to participate in the medicaid/medikan program.

(b) Each ICF-MR shall cooperate with authorized representatives of the agency and the department of health and human services in the discharge of their duties regarding all aspects of the inspection of care and utilization review.

(c) Any ICF-MR where the utilization review team finds inappropriately placed clients shall be responsible for providing transportation for the clients to a more appropriate placement facility. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Oct. 1, 1991.)

**30-10-208. ICF-MR personal needs fund.** (a) At the time of admission, ICF-MR providers shall furnish that client and the representative with a written statement that:

(1) Lists all services provided by the provider, distinguishing between those services included in the provider's per diem rate and those services not included in the provider's basic rate, that can be charged to the client's personal needs fund;

(2) states that there is no obligation for the client to deposit funds with the provider;

(3) describes the client's rights to select one of the following alternatives for managing the personal needs fund:

(A) The client may receive, retain and manage the client's personal needs fund or have this done by a legal guardian, if any;

(B) the client may apply to the social security administration to have a representative payee designated for purposes of federal or state benefits to which the client may be entitled;

(C) except when paragraph (B) of this subsection applies, the client may designate, in writing, another person to act for the purpose of managing the client's personal needs fund;

(4) states that any charge for these services is included in the provider's per diem rate;

(5) states that the provider is required to accept a client's personal needs fund to hold, safeguard, and provide an accounting, upon the written authorization of the client or representative, or upon appointment of the provider as a client's representative payee; and

(6) states that, if, in the opinion of the professional interdisciplinary team, the client becomes incapable of managing the personal needs fund and does not have a representative, the provider is required to arrange for the management of the



client's personal funds as provided in K.A.R. 30-10-208(j).

(b) (1) The provider shall upon written authorization by the client, accept responsibility for holding, safeguarding and accounting for the client's personal needs fund. The provider may make arrangements with a federally or state insured banking institution to provide these services. However, the responsibility for the quality and accuracy of compliance with the requirements of K.A.R. 30-10-208 shall remain with the provider. The provider may not charge the client for these services, but shall include any charges in the provider's per diem rate.

(2) The provider shall maintain current, written, individual records of all financial transactions involving each client's personal needs fund for which the provider has accepted responsibility. The records shall include at least the following:

- (A) The client's name;
- (B) an identification of client's representative, if any;
- (C) the admission date;
- (D) the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction;
- (E) receipts indicating the purpose for which any withdrawn funds were spent; and
- (F) the client's earned interest, if any.

(3) The provider shall provide each client reasonable access to the client's own financial records.

(4) The provider shall provide a written statement, at least quarterly, to each client or representative. The statement shall include at least the following:

- (A) The balance at the beginning of the statement period;
- (B) total deposits and withdrawals;
- (C) the interest earned, if any, and;
- (D) the ending balance.

(c) Commingling prohibited. The provider shall keep any funds received from a client for holding, safeguarding and accounting separate from the provider's operating funds, activity funds, client council funds and from the funds of any person other than another client in that facility.

(d) Types of accounts; distribution of interest.

(1) Petty cash. The provider may keep up to \$50.00 of a client's money in a non-interest bearing account or petty cash fund.

(2) Interest-bearing accounts. The provider shall, within 15 days of receipt of the money, deposit in an interest-bearing account any funds in excess of \$50.00 from an individual client. The account may be individual to the client or pooled with other client accounts. If a pooled account is used, each client shall be individually identified on the provider's books. The account shall be in a form that clearly indicates that the provider does not have an ownership interest in the funds. The account shall be insured under federal or state law.

(3) The interest earned on any pooled interest-bearing account shall be distributed in one of the following ways, at the election of the provider:

(A) Pro-rated to each client on an actual interest-earned basis; or

(B) pro-rated to each client on the basis of the client's end-of-quarter balance.

(e) The provider shall provide the clients with reasonable access to their personal needs funds. The provider shall, upon request or upon the client's transfer or discharge, return to the client, the legal guardian or the representative payee the balance of the client's personal needs fund for which the provider has accepted responsibility, and any funds maintained in a petty cash fund. When a client's personal needs fund for which the provider has accepted responsibility is deposited in an account outside the facility, the provider, upon request or upon the client's transfer or discharge, shall within 15 business days, return to the client, the legal guardian, or the representative payee, the balance of those funds.

(f) When a provider is a client's representative payee and directly receives monthly benefits to which the client is entitled, the provider shall fulfill all of its legal duties as representative payee.

(g) Duties on change of provider.

(1) Upon change of providers, the former provider shall furnish the new provider with a written account of each client personal needs fund to be transferred, and obtain a written receipt for those funds from the new provider.

(2) The provider shall give each client's representative a written accounting of any personal needs fund held by the provider before any change of provider occurs.

(3) In the event of a disagreement with the accounting provided by the previous provider or the new provider, the client shall retain all rights and remedies provided under state law.

(h) Upon the death of a client, the provider

shall provide the executor or administrator of a client's estate with a written accounting of the client's personal needs fund within 30 business days of a client's death. If the deceased client's estate has no executor or administrator, the provider shall provide the accounting to:

- (1) The client's next of kin;
- (2) the client's representative; and
- (3) the clerk of the probate court of the county in which the client died.

(i) The provider shall purchase a surety bond in the name of the provider on behalf of the clients or employee indemnity bond, or submit a letter of credit or individual or corporate surety, to guarantee the security of clients' funds when the amount in the aggregate exceeds \$1,000.00. The guarantee shall be sufficient to secure the highest quarterly balance from the previous year.

(j) If a client is incapable of managing the client's personal needs fund, has no representative, and is eligible for SSI, the provider shall notify the local office of the social security administration and request that a representative be appointed for that client. If the client is not eligible for SSI, the provider shall refer the client to the local agency office, or the provider shall serve as a temporary representative payee for the client until the actual appointment of a guardian or conservator or representative payee.

(k) Client property records.

(1) The provider shall maintain a current, written record for each client that includes written receipts for all personal possessions deposited with the provider by the client.

(2) The property record shall be available to the client and the client's representative.

(l) Providers shall keep the funds in the state of Kansas.

(m) Personal needs fund shall not be turned over to any person other than a duly accredited agent or guardian of the client. With the consent of the client, if the client is able and willing to give consent, the administrator shall turn over a client's personal needs fund to a designated person to purchase a particular item. However, a signed, itemized, and dated receipt shall be required for deposit in the client's personal needs fund envelope or another type of file.

(n) Receipts shall be signed by the client, legal guardian, conservator or responsible party for all transactions. Recognizing that a legal guardian, conservator or responsible party may not be available at the time each transaction is made for or

on behalf of a client, the provider shall have a procedure which includes a provision for signed receipts at least quarterly.

(o) The provider shall provide and maintain a system of accounting for expenditures from the client's personal needs fund. This system shall follow generally accepted accounting principles and shall be subject to audit by representatives of the agency. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Oct. 1, 1991.)

**30-10-209. ICF-MR prospective reimbursement.** Providers participating in the medicaid/medikan program shall be reimbursed for ICF-MR services through rates that are reasonable and adequate to meet the client-related costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. Because even efficiently and economically operated facilities may incur some excess or inefficient costs, in this prospective payment system the identification of efficiently and economically operated facilities by the procedures and limitations of this article shall be an aggregate determination. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Aug. 14, 1998.)

**30-10-210.** (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992; revoked Sept. 19, 2008.)

**30-10-211. ICF-MR financial data.** (a) General. The per diem rate or rates for providers participating in the medicaid/medikan program shall be based on an audit or desk review of the costs reported to provide client care in each facility. The basis for conducting these audits or reviews shall be the ICF-MR financial and statistical report MH&RS-2004. Each provider shall maintain sufficient financial records and statistical data for proper determination of reasonable and adequate rates. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the ICF-MR and related fields shall be followed, except to the extent that they may

conflict with or be superseded by state or federal medicaid requirements. Changes in these practices and systems shall not be required in order to determine reasonable and adequate rates.

(b) Pursuant to K.A.R. 30-10-213, ICF-MR financial and statistical reports, MH&RS-2004, (cost reports) shall be required from providers on an annual basis.

(c) Adequate cost data and cost findings. Each provider shall provide adequate cost data on the cost report. This cost data shall be in accordance with state and federal medicaid requirements and general accounting principles, shall be based on the accrual basis of accounting, and may include a current use value of the provider's fixed assets used in client care. Estimates of costs shall not be allowable except on projected cost reports submitted pursuant to K.A.R. 30-10-213.

(d) Recordkeeping requirements.

(1) Each provider shall furnish any information to the agency that may be necessary:

(A) To assure proper payment by the program pursuant to paragraph (2);

(B) to substantiate claims for program payments; and

(C) to complete determinations of program overpayments.

(2) Each provider shall permit the agency to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall include:

(A) Matters of the ICF-MR ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(B) fiscal, medical, and other recordkeeping systems;

(C) federal and state income tax returns and all supporting documents;

(D) documentation of asset acquisition, lease, sale or other action;

(E) franchise or management arrangements;

(F) matters pertaining to costs of operation;

(G) amounts of income received, by source and purpose;

(H) a statement of changes in financial position; and

(I) actual cost of day care programs provided to ICF/MR clients.

Other records and documents shall be made available as necessary. Records and documents shall be made available in Kansas. Any provider

who fails to provide any documents requested by the agency may be suspended from the ICF/MR program.

(3) Each provider, when requested, shall furnish the agency with copies of client service charge schedules and changes thereto as they are put into effect. The agency shall evaluate the charge schedules to determine the extent to which they may be used for determining program payment.

(4) Suspension of program payments to a provider. If the agency determines that any provider does not maintain or no longer maintains adequate records for the determination of reasonable and adequate per diem rates under the program, payments to that provider may be suspended until deficiencies are corrected. Thirty days before suspending payment to the provider, the agency shall send written notice to the provider of its intent to suspend payments. The notice shall explain the basis for the agency's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies.

(5) All records of each provider that are used in support of costs, charges and payments for services and supplies shall be subject to inspection and audit by the agency, the United States department of health and human services, and the United States general accounting office. All financial and statistical records to support costs reports shall be retained for five years from the date of filing the cost report with the agency. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

**30-10-212. ICF-MR extra care.** (a) Additional reimbursement for direct services shall be available to ICF's-MR for medicaid/medikan clients in need of extra care. Failure to obtain prior authorization shall negate reimbursement for this service.

(b) Extra care shall be considered a covered service within the scope of the program unless the request for prior authorization is denied. Reimbursement for this service shall be contingent on approval by the agency.

(c) The additional reimbursement for extra care shall be shown as a provider adjustment on the individual line item of benefit on the ICF-MR financial and statistical report. Extra care costs shall not be included as a component when cal-

culating the final rate for the facility. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

**30-10-213. ICF-MR cost reports.** (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the ICF-MR financial and statistical report in accordance with the instructions included in this regulation. The report shall cover a consecutive 12-month period of operations. The 12-month period shall coincide with the fiscal year used for federal income tax or other financial reporting purposes. The same 12-month period shall be used by providers related through common ownership, common interests or common control. A non-owner operator of a facility must have a signed provider agreement to be considered a provider for the purpose of this paragraph. A working trial balance, as defined in K.A.R. 30-10-200, and a detailed depreciation schedule shall be submitted with the cost report.

(2) If a provider has more than one facility, the provider shall allocate central office costs to each facility consistently, based on generally accepted accounting principles, including any facilities being paid rates from projected cost data.

(b) Amended cost reports. Amended cost reports revising cost report information previously submitted by a provider shall be required when the error or omission is material in amount and results in a change in the provider's rate of \$.10 or more per client day. Amended cost reports shall also be permitted when the error or omission affects the current or future accounting periods of the provider. No amended cost report shall be allowed after 13 months have passed from the report year end.

(c) Due dates of cost reports. Cost reports shall be received by the agency no later than the close of business on the last day of the third month following the close of the period covered by the report. Cost reports from each provider with more than one facility shall be received on the same date.

(d) Extension of time for submitting a cost report to be received by the agency.

(1) A one-month extension of the due date of a cost report may, for good cause, be granted by the agency. The request shall be in writing and

shall be received by the agency prior to the due date of the cost report. Requests received after the due date shall not be accepted.

(2) A second extension may be granted in writing by the secretary of the agency when the cause for further delay is beyond the control of the provider.

(3) Each provider who requests an extension of time for filing a cost report to delay the effective date of the new rate, which is lower than the provider's current rate, shall have the current rate reduced to the amount of the new rate. The reduced rate shall be effective on the date that the new rate would have been effective if the cost report had been received on the last day of the filing period without the extension.

(e) Penalty for late filing. Except as provided in subsection (d), each provider filing a cost report after the due date shall be subject to the following penalties.

(1) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be withheld and suspended until the complete ICF-MR financial and statistical report has been received.

(2) Failure to submit cost information within one year after the end of the provider's fiscal year shall be cause for termination from the medicaid/medikan program.

(f) Projected cost data.

(1) If a provider is required to submit a projected cost report under K.A.R. 30-10-214, the provider's rate or rates shall be based on a proposed budget with costs projected on a line item basis for the provider's most immediate future 12-month period.

(2) The projection period shall end on the last day of a calendar month. Providers shall use the last day of the month nearest the end of the 12-month period specified in subparagraph (1) or the end of their fiscal year when that period ends not more than one month before or after the end of the 12-month report period. The projection period shall not be less than 11 months or more than 13 months. Historical cost data reported shall be for the full period reported if that period is less than 12 months or the latest consecutive 12-month period if the report period is extended beyond 12 months to meet this requirement.

(3) The projected cost report shall be approved for reasonableness and appropriateness by the agency before the rate or rates are established for



the projection period, and upon receipt of the provider's historical cost report for the time period covered by the projected cost report. The projected cost report items which are determined to be unreasonable or which contain deviations from the historical cost report shall, upon audit, be handled in accordance with subsection (f) of K.A.R. 30-10-214.

(4) The projection period of each provider filing a projected cost report in accordance with paragraph (2) of subsection (e) of K.A.R. 30-10-214 shall be extended to the last day of the 12th month following the date the new construction is certified for use by the appropriate agency. The projected and historical cost reports for this projection period shall be handled in accordance with paragraph (1) of this subsection. If the projection period prior to the certification of the new construction exceeds three months, the provider shall be required to file a historical cost report for this period for the purpose of retroactive settlement in accordance with paragraph (1) of this subsection.

(5) An interim settlement, based on a desk review of the historical cost report for the projection period, may generally be determined within 90 days after the provider is notified of the new rate determined from such cost report. The final settlement shall be based on an audit of the historical cost report.

(g) Balance sheet requirement. A balance sheet prepared in accordance with cost report instructions shall be filed as part of the cost report forms for each provider. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

**30-10-214. ICF-MR rates of reimbursement.** (a) Rates for ICF's-MR.

(1) The determination of per diem rates shall be made, at least annually by the secretary, on the basis of the cost information supplied by the provider, and retained for cost auditing. The cost information for each provider shall be compared with limits established based on the level of care needs of clients to determine the allowable per diem cost.

(2) Ownership allowance shall be determined as follows:

(A) All ICF's-MR initially certified to participate in the medicaid/medikan program prior to

July 1, 1991 shall be held to the established ownership allowance.

(B) All ICF's-MR certified on or after July 1, 1991 shall be subject to an absolute cap on ownership costs.

(3) Per diem rates for the following cost centers shall be limited by absolute caps.

(A) The cost center limits shall be based on facility size and level of care. The cost centers and limiting factors shall be:

(i) Direct service based on facility size and level of care. Direct service consists of the room and board and health care cost centers in the ICF-MR financial and statistical report;

(ii) administration based on facility size; and

(iii) plant operating based on total allowable costs;

(B) The absolute caps shall be reviewed at least annually for reasonableness based on the reimbursement model and the allowable historical costs. The absolute caps shall be approved by the secretary or a designated official.

(4) To establish a per diem rate for each provider by facility size and level of care, a factor for inflation may be added to the allowable per diem cost. The per diem rate shall be based on the lower of the actual allowable cost or the absolute cost center limits. A detailed listing of the computation of the rate shall be provided to each provider. The effective date of the rate for existing facilities shall be in accordance with subsection (a) of K.A.R. 30-10-215.

(b) Comparable service rate limitations.

(1) Intermediate care facilities for the mentally retarded and persons with related conditions. The per diem rate for intermediate care for the mentally retarded and persons with related conditions shall not exceed the rate charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR and for the same type of service.

(2) All private pay rate structure changes and the effective dates shall be reported on the uniform cost report.

(3) The ICF-MR shall notify the agency of any private pay rate structure changes within 30 days of the effective date of a new medicaid rate.

(4) Providers shall have a grace period to raise the rate or rates charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR.

(A) The grace period shall end the first day of

the third calendar month following the notification date of a new medicaid/medikan rate.

(B) The notification date is the date typed on the letter which informs the provider of a new medicaid/medikan rate.

(C) There shall be no penalty during the grace period if the rate charged to clients not under the medicaid/medikan program is lower than the medicaid/medikan rate for the same level of care in the ICF-MR and for the same type of service.

(D) If the rate charged to clients not under the medicaid/medikan program is lower than the rate charged to medicaid/medikan clients after the grace period, the medicaid/medikan rate will be lowered as of the original effective date of the most recent changes.

(c) Rates for new construction or bed additions. The per diem rate for newly constructed ICF's-MR shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-213. No rate shall be paid until an ICF-MR financial and statistical report is received and approved. Limitations established for existing facilities providing the same level of care shall apply. The effective date of the per diem rate shall be in accordance with K.A.R. 30-10-215.

(d) Change of provider.

(1) When a new provider makes no change in the facility, number of beds or operations, the interim payment rate for the first 12 months of operation shall be based on the historical cost data of the previous owner or provider. The new owner or provider shall file a 12-month historical cost report within three months after the end of the first 12 months of operation and within three months after the end of the provider's fiscal year established for tax or accounting purposes. The rate determined from the historical cost reports shall be effective in accordance with K.A.R. 30-10-215.

(2) The agency may approve a new rate based on a projected cost report when the care of the clients is certified by the Kansas department of health and environment to be at risk because the per diem rate of the previous provider is not sufficient for the new provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

(e) Per diem rate errors.

(1) When the per diem rate, whether based upon projected or historical cost data, is audited by the agency and is found to contain errors, a

direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may be made when a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of per diem rate changes and desk review or audit findings shall be sent to the provider. Retroactive adjustments of the rate paid during any projection period shall apply to the same period of time covered by the projected rate.

(3) Providers may request an administrative review of the audit adjustments that result in an overpayment or underpayment within 30 days from the date of the audit report cover letter. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) Any audit exception imposed on the agency by the department of health and human services due to provider action may be recovered from the provider.

(f) ICF-MR closure. An ICF-MR may submit a plan to the agency to individually place all residents out of the facility, close the facility permanently and cease operations as a certified ICF-MR.

(1) The plan for ICF-MR closure shall include:

(A) A schedule for the placement of residents out of the facility; and

(B) a projected budget for the cost of operating the facility while closure is occurring.

(2) The plan for ICF-MR closure shall be reviewed for reasonableness. If approved by the secretary, the plan may be implemented as written.

(3) The facility may be reimbursed on a projected basis for cost of operating the facility while closure is occurring according to the agreed upon plan. Reimbursement may exceed limits established for any cost centers for ICF's-MR including but not limited to:

(A) Administration;

(B) ownership allowance;

(C) plant operating; and

(D) direct service, including room and board and habilitation.

(4) After the ICF-MR ceases operation, an au-

dit of the actual costs incurred during implementation of the approved closure plan shall be conducted.

(A) If the actual overall costs incurred during closure are not as great as the costs projected in the approved closure plan, the facility shall repay the difference to the agency.

(B) If the actual overall cost incurred during closure meets or exceeds the projected costs in the approved closure plan, no additional payment shall be made to the ICF-MR.

(5) If the ICF-MR does not close as agreed upon, the ICF-MR must repay the excess of the amount paid under the closure agreement above the regular payments the ICF-MR would have received, based on the most recent historical actual cost report, if the ICF-MR had not submitted a closure plan to the agency.

(g) Provision of services out-of-state. Rates for clients served out-of-state by certified participants in a medicaid program shall be the rate or rates approved by the agency. All payments made for services provided outside the state of Kansas require prior authorization by the agency. The effective date of this regulation shall be October 1, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by 1992 SB 182, Sec. 5; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended Oct. 1, 1992.)

**30-10-215. ICF-MR rates; effective dates.** (a) Effective date of per diem rates for existing facilities. The effective date of a new rate that is based on information and data in the ICF/MR cost report shall be the first day of the third calendar month following the month the complete cost report is received by the agency.

(b) Effective date of the per diem rate for a new provider. The effective date of the per diem rate for a new provider, as set forth in subsection (c) of K.A.R. 30-10-214, shall be the date of certification by the department of health and environment pursuant to 42 CFR section 442.13, effective October 3, 1988, which is adopted by reference. The interim rate determined from an approved projected cost report filed by the provider shall be established with the fiscal agent by the first day of the third month after the receipt of a complete and workable cost report. The effective date of the final rate, determined after audit of the historical cost report filed for the pro-

jection period, shall be the date of certification by the department of health and environment.

(c) Effective date of the per diem rate for a new provider resulting from a change in provider.

(1) The effective date of the per diem rate for a change in provider, as set forth in K.A.R. 30-10-215, shall be the date of certification by the department of health and environment. The effective date of the final rate, determined after audit of the historical cost report filed for the projection period, shall be the date of certification by the department of health and environment.

(2) The effective date of the projected and final rate for a new provider, as set forth in K.A.R. 30-10-214, shall be the later of the date of the receipt of the ICF-MR financial and statistical report or the date the new construction is certified.

(d) The effective date of the per diem rates for providers with more than one facility filing an historic cost report, in accordance with K.A.R. 30-10-213, shall be the first day of the third calendar month after all cost reports due from that provider have been received.

(e) The effective date for a provider filing an historic cost report covering a projection status period shall be the first day of the month following the report year-end. This is the date that historic and estimated inflation factors are applied in determining prospective rates. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

### **30-10-216. ICF-MR payment of claims.**

(a) Payment to participating provider. Each participating provider shall be paid, at least monthly, a per diem rate for ICF-MR services, excluding client liability, rendered to eligible clients provided that:

(1) The agency is billed on the turn-around document or electronic claims submission furnished by the contractor serving as the fiscal agent for the medicaid/medikan program;

(2) the turn-around document or electronic claims submission is verified by the administrator of the facility or a designated key staff member; and

(3) the claim is filed no more than six months after the time the services were rendered pursuant to K.S.A. 39-708a, and any amendments thereto.

(b) Client's liability. The client's liability for

services shall be the amount determined by the local agency office in which a medicaid/medikan client or the client's agent applies for care. The client's liability begins on the first day of each month and shall be applied in full prior to any liability incurred by the medicaid/medikan program. The unexpended portion of the client's liability payment shall be refunded to the client or client's agent if the client dies or otherwise permanently leaves the facility.

(c) The payment of claims may be suspended if there has been an identified overpayment and the provider is financially insolvent. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991.)

**30-10-217. ICF-MR reserve days.** (a) Payment shall be available for days for which it is necessary to reserve a bed in an intermediate care facility for the mentally retarded when the client is absent for:

- (1) admission to a hospital for acute conditions;
- (2) therapeutically indicated home visits with relatives or friends; or

(3) participation in state-approved therapeutic or rehabilitative programs.

(b) (1) Payment shall be available only for the days during which there is a likelihood that the reserved bed would otherwise be required for occupancy by some other client.

(c) The provider shall notify the local agency office before routine absence from the facility by clients in the Kansas medicaid/medikan program. In case of emergency admission to a hospital, the provider shall notify the local agency office not later than five working days following admission.

(d) In order for payment to be available, the following conditions shall be met when a bed is reserved in an ICF/MR because of hospitalization.

(1) The provider shall be reimbursed for client reserve days for hospitalization of an acute condition for each period of hospitalization up to 10 days.

(2) ICF/MR clients transferred to one of the state mental retardation facilities, shall be eligible for 21 hospital reserve days.

(3) The client shall intend to return to the same facility after the hospitalization and the facility shall intend to accept the individual for service.

(4) The hospital shall provide a discharge plan for the client which includes returning to the facility requesting the reserve days.

(5) An ICF/MR which has less than 90 percent occupancy shall not be approved for hospitalization reserve days.

(e) The client's plan of care shall provide for any non-hospital related absence. Payment for non-hospital related reserve days for eligible clients residing in intermediate care facilities for the mentally retarded shall not exceed 21 days per calendar year, including travel. If additional days are required to alleviate a severe hardship or facilitate normalization, the ICF-MR provider shall send the request for additional days and supporting documentation to the agency for approval or disapproval.

(f) This regulation shall not prohibit any client from leaving a facility if the client so desires.

(g) Payments made for unauthorized reserve days shall be reclaimed by the agency.

(h) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992; amended July 1, 1996.)

**30-10-218. ICF-MR non-reimbursable costs.** (a) Costs not related to client care, as set forth in K.A.R. 30-10-200, shall not be considered in computing reimbursable costs. In addition, the following expenses or costs shall not be allowed:

(1) Fees paid to non-working directors and the salaries of non-working officers;

(2) bad debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes, including:

(A) Federal income and excess profit taxes, including any interest or penalties paid;

(B) state or local income and excess profits taxes;

(C) taxes from which exemptions are available to the provider;

(D) taxes on property which is not used in providing covered services;

(E) taxes levied against any client and collected and remitted by the provider;

(F) self-employment taxes applicable to individual proprietors, partners, or members of a joint venture; and

(G) interest or penalties paid on federal and state payroll taxes;

(6) insurance premiums on lives of officers and owners;



(7) the imputed value of services rendered by non-paid workers and volunteers;

(8) utilization review;

(9) costs of social, fraternal, and other organizations which concern themselves with activities unrelated to their members' professional or business activities;

(10) oxygen;

(11) vending machine and related supplies;

(12) board of director costs;

(13) client personal purchases;

(14) barber and beauty shop expenses;

(15) advertising for client utilization;

(16) public relations expenses;

(17) penalties, fines, and late charges;

(18) items or services provided only to non-medicaid/medikan clients and reimbursed from third party payors;

(19) automobiles and related accessories in excess of \$25,000.00. Buses and vans for client transportation shall be reviewed for reasonableness and may exceed \$25,000.00 in costs;

(20) airplanes and associated expenses;

(21) costs of legal fees incurred in actions brought against the agency;

(22) aggregate costs incurred in excess of historical or projected costs plus allowed inflation, without prior authorization of the agency; and

(23) costs incurred through providing service to a bed made available through involuntary discharge of a client as determined by the Kansas department of health and environment without prior authorization of the agency.

(b) The following contract costs under the day habilitation program shall not be allowed:

(1) Client salaries and FICA match;

(2) any material costs, including sub-contracts;

(3) any costs related to securing contracts; and

(4) 50 percent of the cost of the following items:

(A) Cost of equipment lease;

(B) maintenance of equipment;

(C) purchase of small tools under \$100.00; and

(D) depreciation of production equipment.

(c) Private ICFs/MR shall not be reimbursed for services provided to individuals admitted on or after the effective date of this regulation unless the community developmental disability organization (CDDO) assigned by the agency first determines such persons meet eligibility requirements established by the agency and the ICF/MR placement is consistent with the preferred life-style of the person as specified by the person or

the person's guardian, if one has been appointed. (Authorized by and implementing K.S.A. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended May 10, 1996.)

**30-10-219. ICF-MR costs allowed with limitations.** (a) The following expenses or costs shall be allowed with limitations:

(1) Loan acquisition fees and standby fees shall be amortized over the life of the related loan if the loan is related to client care.

(2) Only the taxes specified below shall be allowed as amortized costs.

(A) Taxes in connection with financing, re-financing, or re-funding operations; and

(B) special assessments on land for capital improvements over the estimated useful life of those improvements.

(3) Purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior year expense payments shall also be deducted from the related expenses.

(4) Any start-up cost of a provider shall be recognized if it is:

(A) Incurred prior to the opening of the facility and related to developing the ability to care for clients;

(B) amortized over a period of not less than 60 months;

(C) consistent with the facility's federal income tax return, and internal and external financial reports with the exception of (B) above; and

(D) identified in the cost report as a start-up cost which may include:

(i) Administrative salaries limited to three months prior to licensing;

(ii) employee salaries limited to one month prior to licensing;

(iii) utilities;

(iv) taxes;

(v) insurance;

(vi) mortgage interest;

(vii) employee training costs; and

(viii) any other allowable costs incidental to the start-up of the facility as prior approved by the agency.

(5) Any cost which can properly be identified as organization expenses or can be capitalized as construction expenses shall be appropriately classified and excluded from start-up cost.

(6) Organization and other corporate costs, as

defined in K.A.R. 30-10-200, of a provider that is newly organized shall be amortized over a period of not less than 60 months beginning with the date of organization.

(7) Membership dues and costs incurred as a result of membership in professional, technical, or business-related organizations shall be allowable. However, similar expenses set forth in paragraph (a)(9) of K.A.R. 30-10-218 shall not be allowable.

(8) (A) Costs associated with services, facilities, and supplies furnished to the ICF-MR by related parties, as defined in K.A.R. 30-10-200, shall be included in the allowable cost of the facility at the actual cost to the related party, except that the allowable cost to the ICF-MR provider shall not exceed the lower of the actual cost or the market price.

(B) When a provider chooses to pay an amount in excess of the market price for supplies or services, the agency shall use the market price to determine the allowable cost under the medicaid/medikan program in the absence of a clear justification for the premium.

(9) The net cost of approved staff educational activities shall be an allowable cost. The net cost of "orientation" and "on-the-job training" shall not be within the scope of approved educational activities, but shall be recognized as normal operating costs.

(10) Client-related transportation costs shall include only reasonable costs that are directly related to client care and substantiated by detailed, contemporaneous expense and mileage records. Transportation costs only remotely related to client care shall not be allowable. Estimates shall not be acceptable.

(11) Lease payments. Lease payments shall be reported in accordance with the financial account statements of the Financial Accounting Standards Board.

(12) The actual cost of airplanes and associated expenses are not allowed. However, the provider may charge the equivalent distance of automobile mileage at the IRS allowable rate. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

**30-10-220. ICF-MR revenues.** A statement of revenue shall be required as part of the cost report forms. (a) Revenue shall be reported

in accordance with general accounting rules as recorded in the accounting records of the facility and as required in the detailed revenue schedule in the uniform cost report.

(b) The non-reimbursable cost of goods and services provided to clients shall be deducted from the related expense item. The net expense shall not be less than zero.

(c) Revenue received for a service that is not related to client care shall be used to offset the cost of providing that service provided that excess revenue received for such service shall be distributed to the entire agency based on generally accepted accounting principles. The cost report line item which includes the non-client related costs shall not be less than zero. Miscellaneous revenue with insufficient explanation in the cost report shall be offset.

(d) Expense recoveries credited to expense accounts shall not be reclassified as revenue to increase the costs reported in order to qualify for a higher rate.

(e) Each ICF-MR provider with a day habilitation program shall not be required to deduct the income earned from the costs incurred on contracts. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

**30-10-221. ICF-MR compensation of owners, spouses, related parties and administrators.** (a) Non-working owners and related parties. Remunerations paid to non-working owners or other related parties, as defined in K.A.R. 30-10-200, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-client related expense section of the cost report.

(b) Services related to client care.

(1) If owners with 5% or more ownership interest, spouses, or related parties actually perform a necessary function directly contributing to client care, a reasonable amount shall be allowed for such client care activity. The reasonable amount allowed shall be the lesser of:

(A) The reasonable cost that would have been incurred to pay a non-owner employee to perform the client-related services actually performed by

owners or other related parties, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed until the subsequent cost report is filed; or

(B) the amount of cash and other assets actually withdrawn by the owner, spouse, or related parties.

(2) The client-related functions shall be limited to those functions common to the industry and for which cost data is available which are normally performed by non-owner employees. The job titles for administrative and supervisory duties performed by an owner, spouse, or related party shall be limited to the work activities included in the schedule of the owner, spouse, or related party salary limitations.

(3) The salary limit shall also be pro-rated in accordance with subsection (c) of this regulation. In no case shall the limitation exceed the highest salary limit on the civil-service-based chart.

(4) The owner, spouse, or related party shall be professionally qualified for those functions performed which require licensure or certification.

(5) Cash and other assets actually withdrawn shall include only those amounts or items actually paid or transferred during the cost reporting period in which the services were rendered and reported to the internal revenue service.

(6) Any liabilities of the provider shall be paid in cash within 75 days after the end of the accounting period.

(c) Allocation of owner, spouse, or related party total work time for client-related functions. When any owner, spouse, or related party performs a client-related function for less than a full-time-equivalent work week, the compensation limit shall be pro-rated. The time spent on each function within a facility or within all facilities in which they have an ownership or management interest, shall be pro-rated separately by function, but shall not exceed 100% of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.

(d) Reporting owner, spouse, or related party compensation on cost report. Owner, spouse, or related party compensation shall be reported on the owner compensation line in the appropriate cost center for the work activity involved. Any compensation paid to employees who have an ownership interest of 5% or more, including employees at the central office of a chain organiza-

tion, shall be considered to be owner compensation. Providers with professionally qualified owner, spouse, or related party employees performing duties other than those for which they are professionally qualified shall report the cost for such duties in the administrative cost center.

(e) Owner-administrator compensation limitation.

(1) Reasonable limits shall be determined by the agency for owner-administrator compensation based upon the current civil service salary schedule.

(2) This limitation shall apply to the salaries of each administrator and co-administrator of that facility and to owner compensation reported in the administrative cost center of the cost report. This limitation shall apply to the salary of the administrator and co-administrator, regardless of whether they have any ownership interest in the business entity.

(3) Each salary in excess of the owner, spouse, or related party limitations determined in accordance with subsections (b) and (c) of this regulation shall be transferred to the owner compensation line in the administrative cost center and shall be subject to the owner-administrator compensation limitation.

(f) Management consultant fees. Fees for consulting services provided by the following professionally qualified people shall be considered owner's compensation subject to the owner-administrator compensation limit and shall be reported on the owner compensation line in the administrative cost center if the actual cost of the service is not submitted with the ICF-MR financial and statistical report:

(1) Related parties as defined in K.A.R. 30-10-200;

(2) current owners of the provider agreement and operators of the facility;

(3) current owners of the facility in a lessor-lessee relationship;

(4) management consulting firms owned and operated by former business associates of the current owners in this and other states;

(5) owners who sell and enter into management contracts with the new owner to operate the facility; and

(6) accountants, lawyers and other professional people who have common ownership interests in other facilities, in this or other states, with the owners of the facility from which the consulting fee is received.

(g) Costs not related to client care. An allowance shall not be made for costs related to investigation of investment opportunities, travel, entertainment, goodwill, administrative or managerial activities performed by owners or other related parties that are not directly related to client care. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

**30-10-222. ICF-MR ownership reimbursement fee.** (a) The agency shall determine an allowable cost for ownership.

(b) (1) The ownership allowance shall include an appropriate component for:

- (A) Rent or lease expense;
- (B) interest expense on real estate mortgage;
- (C) amortization of leasehold improvements; and
- (D) depreciation on buildings and equipment.

(2) The ownership allowance shall be subject to a facility maximum.

(c) (1) The depreciation component of the ownership allowance shall be:

- (A) Identifiable and recorded in the provider's accounting records;
- (B) based on the historical cost of the asset as established in this regulation; and
- (C) pro-rated over the estimated useful life of the asset using the straight-line method.

(2) (A) Appropriate recording of depreciation shall include identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, the assets' estimated useful life, and the assets' accumulated depreciation.

(B) Gains and losses on the sale of depreciable personal property shall be reflected on the cost report at the time of such sale. Trading of depreciable property shall be recorded in accordance with the income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets are not recognized in the year of trade but are used to adjust the basis of the newly acquired property.

(3) (A) Gains from the sale of depreciable assets while the provider participates in the medicare/medicaid program, or within one year after the provider terminates participation in the program, shall be used to reduce the allowable costs for each cost reporting period prior to the sale,

subject to limitation. The total sale price shall be allocated to the individual assets sold on the basis of an appraisal by a qualified appraiser or on the ratio of the seller's cost basis of each asset to the total cost basis of the assets sold.

(B) The gain on the sale shall be defined as the excess of the sale price over the cost basis of the asset. The cost basis for personal property assets shall be the book value. The cost basis for real property assets sold or disposed of before July 18, 1984, shall be the lesser of the book value adjusted for inflation by a price index selected by the agency or an appraisal by an American institute of real estate appraiser or an appraiser approved by the agency. The cost basis for real property assets sold or disposed of after July 17, 1984 shall be the book value.

(C) The gain on the sale shall be multiplied by the ratio of depreciation charged while participating in the medicare/medicaid program to the total depreciation charged since the date of purchase or acquisition. The resulting product shall be used to reduce allowable cost.

(4) For depreciation purposes, the cost basis for a facility acquired after July 17, 1984 shall be the lesser of the acquisition cost to the holder of record on that date or the purchase price of the asset. The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, including legal fees, accounting fees, travel costs and the cost of feasibility studies. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991.)

**30-10-223. ICF-MR interest expense.**

(a) Only necessary and proper interest on working capital indebtedness shall be an allowable cost.

(b) The interest expense shall be incurred on indebtedness established with:

- (1) Lenders or lending organizations not related to the borrower; or
- (2) partners, stockholders, home office organizations, or related parties, if the following conditions are met:

(A) The terms and conditions of payment of the loans shall resemble terms and conditions of an arms-length transaction by a prudent borrower with a recognized, local lending institution with the capability of entering into a transaction of the required magnitude.

(B) The provider shall demonstrate, to the sat-



isfaction of the agency, a primary business purpose for the loan other than increasing the per diem rate.

(C) The transaction shall be recognized and reported by all parties for federal income tax purposes.

(c) When the general fund of an ICF-MR "borrows" from a donor-restricted fund, this interest expense shall be an allowable cost if it is considered by the agency to be reasonable. In addition, if an ICF-MR operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

(d) The interest expense shall be reduced by the investment income from restricted or unrestricted idle funds or funded reserve accounts, except when that income is from gifts and grants, whether restricted or unrestricted, which are held in a separate account and not commingled with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

(e) Interest earned on restricted or unrestricted reserve accounts of industrial revenue bonds of sinking fund accounts shall be offset against interest expense and limited to the interest expense on the related debt.

(f) Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost or the cost basis recognized for program purposes shall not be considered to be reasonably related to client care. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-12-28-40, Dec. 28, 1940; effective March 4, 1991.)

**30-10-224. ICF-MR central office costs.**

(a) Allocation of central office costs shall be reasonable, conform to general accounting rules, and allowed only to the extent that the central office is providing a service normally available in the ICF-MR. Central office costs shall not be recognized or allowed to the extent they are unreasonably in excess of similar ICF's-MR in the program. The burden of furnishing sufficient evidence to establish a reasonable level of costs shall be on the provider. All expenses reported as central office cost shall be limited to the actual client-related costs of the central office.

(b) Expense limitations.

(1) Salaries of professionally qualified employees performing the duties for which they are professionally qualified shall be allocated to the room

and board and health care cost centers as appropriate for the duties performed. Professionally qualified employees include licensed and registered nurses, dietitians, qualified mental retardation professionals, and other as may be designated by the secretary.

(2) Salaries of chief executives, corporate officers, department heads, and employees with ownership interests of 5% or more shall be considered owner's compensation and shall be reported as owner's compensation in the administrative cost center. Salaries of the chief executive officers of non-profit organizations shall also be considered owner's compensation and included in the administrative cost center.

(3) The salary of an owner or related party performing a client-related service for which such person is professionally qualified shall be included in the appropriate cost center for that service.

(4) Salaries of all other central office personnel performing client-related administrative functions shall be reported in the administrative cost center.

(5) All providers operating more than one facility shall complete and submit detailed schedules of all salaries and expenses incurred for each fiscal year. Failure to submit detailed central office expenses and allocation methods shall result in the cost report being considered incomplete. Methods for allocating all program costs to all facilities in this and other states shall be submitted for prior approval. Changes in these methods shall not be permitted without prior approval.

(6) A central office cost limit may be established by the agency within the overall administrative cost center limit. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991.)

**30-10-225. ICF-MR client days.** (a) Calculation of client days.

(1) Client day has the meaning set forth in K.A.R. 30-10-200.

(2) If both admission and discharge occur on the same day, that day shall be considered to be a day of admission and shall count as one client day.

(3) If the provider does not make refunds on behalf of a client for unused days in case of death or discharge, and if the bed is available and actually used by another client, these unused days shall not be counted as a client day.

(4) Any bed days paid for by the client, or any

other party on behalf of the client, before an admission date shall not be counted as a client day.

(5) The total client days for the cost report period shall be precise and documented; an estimate of the days of care provided shall not be acceptable.

(6) In order to facilitate accurate and uniform reporting of client days, the accumulated method format set forth in forms prescribed by the secretary shall be used for all clients. These forms shall be submitted to the agency as supportive documentation for the client days shown on the cost report forms and shall be submitted at the time the cost report forms are submitted to the agency. Each provider shall keep these monthly records for each client, whether a medicaid/medikan recipient or a non-recipient. If a provider fails to keep accurate records of client days in accordance with the accumulated method format, the assumed occupancy rate shall be 100%.

(7) The provider shall report the total number of medicaid/medikan client days in addition to the total client days on the uniform cost report form.

(b) Any provider which has an occupancy rate of less than 90% for the cost report period shall calculate client days at a minimum occupancy of 90%.

(c) The minimum occupancy rate shall be determined by multiplying the total licensed bed days available by 90%. Therefore, in order to participate in the medicaid/medikan program, each ICF-MR provider shall obtain proper certification for all licensed beds.

(d) Respite care days shall be counted as client days and reported on the monthly census forms.

(e) Day care and day treatment shall be counted as one client day for 18 hours of service. The total hours of service provided for all clients during the cost reporting year shall be divided by 18 hours to convert to client days. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991.)

**30-10-226.** This rule and regulation shall expire on October 1, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; revoked Oct. 1, 1991.)

#### **Article 11.—COMMUNITY BASED GROUP BOARDING HOMES FOR CHILDREN AND YOUTH**

**30-11-1 to 30-11-5.** (Authorized by K.S.A. 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1974.)

**30-11-6 to 30-11-8.** (Authorized by K.S.A. 39-1303, 75-5321; effective Jan. 1, 1974; revoked May 1, 1982.)

#### **Article 12.—SERVICES FOR THE BLIND**

**30-12-1.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1972; revoked May 1, 1982.)

**30-12-2.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1972; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-12-3.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-12-4.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; revoked May 1, 1982.)

**30-12-5.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1972; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-12-6 and 30-12-7.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; revoked May 1, 1982.)

**30-12-8 and 30-12-9.** (Authorized by K.S.A. 1968 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1969.)

**30-12-10.** (Authorized by K.S.A. 1971 Supp. 39-708; effective Jan. 1, 1967; amended Jan. 1, 1969; revoked Jan. 1, 1972.)

**30-12-11.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; revoked May 1, 1982.)

**30-12-12.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-12-13.** (Authorized by and implementing K.S.A. 39-708c, 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-12-14.** (Authorized by K.S.A. 1979 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1980.)

**30-12-15.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1973; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-12-16.** (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1982; amended May 1, 1985; amended May 1, 1986; revoked March 29, 2002.)

**30-12-17.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; revoked March 29, 2002.)

**30-12-18.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; revoked March 29, 2002.)

**30-12-19.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; revoked March 29, 2002.)

**30-12-20.** (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1982; amended May 1, 1985; revoked March 29, 2002.)

**30-12-21.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; revoked March 29, 2002.)

**30-12-22.** (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1982; amended May 1, 1983; amended May 1, 1985; amended May 1, 1986; revoked March 29, 2002.)

#### **Article 13.—VENDING FACILITIES OPERATED BY THE DIVISION OF SERVICES FOR THE BLIND**

**30-13-1.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-13-2.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1976; amended May 1, 1981; revoked May 1, 1982.)

**30-13-3 and 30-13-4.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; revoked May 1, 1982.)

**30-13-5.** (Authorized by and implementing K.S.A. 75-3340; effective Jan. 1, 1972; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-13-6.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; revoked May 1, 1982.)

**30-13-7.** (Authorized by and implementing

K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-13-8.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1981; revoked May 1, 1982.)

**30-13-9.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1972; amended Jan. 1, 1974; revoked May 1, 1982.)

**30-13-10.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended May 1, 1981; revoked May 1, 1982.)

**30-13-11.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; revoked May 1, 1982.)

**30-13-12.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1972; revoked May 1, 1982.)

**30-13-13 to 30-13-16.** (Authorized by and implementing K.S.A. 39-708c; effective Jan. 1, 1967; revoked May 1, 1982.)

**30-13-17.** (Authorized by and implementing K.S.A. 75-3339; effective May 1, 1982; revoked March 29, 2002.)

**30-13-18.** (Authorized by and implementing K.S.A. 75-3339; effective May 1, 1982; revoked March 29, 2002.)

**30-13-19.** (Authorized by and implementing K.S.A. 75-3339; effective May 1, 1982; revoked March 29, 2002.)

**30-13-20.** (Authorized by and implementing K.S.A. 75-3339; effective May 1, 1982; revoked March 29, 2002.)

**30-13-21.** (Authorized by and implementing K.S.A. 75-3339; effective May 1, 1982; revoked March 29, 2002.)

**30-13-22.** (Authorized by K.S.A. 75-3340; implementing K.S.A. 75-3337; effective May 1, 1982; revoked March 29, 2002.)

**30-13-23.** (Authorized by and implementing K.S.A. 75-3340; effective May 1, 1982; amended May 1, 1983; revoked March 29, 2002.)

**30-13-24.** (Authorized by and implementing K.S.A. 75-3340; effective May 1, 1982; revoked March 29, 2002.)

**30-13-25.** (Authorized by and implementing K.S.A. 75-3340; effective May 1, 1982; revoked March 29, 2002.)

**30-13-26.** (Authorized by and implementing K.S.A. 75-3340; effective May 1, 1982; revoked March 29, 2002.)

#### **Article 14.—CHILDREN’S HEALTH INSURANCE PROGRAM**

##### **30-14-1. Establishment of healthwave.**

(a) A health insurance program shall be established and administered by the secretary, under title XXI of the social security act, 42 U.S.C. §1397aa, for children who are residents of Kansas and who are eligible under these regulations. This program shall be known as healthwave. Coverage under the program shall begin January 1, 1999.

(b) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-2. HealthWave eligibility definitions.** (a) The following words and terms, when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

(1) “Caretaker” means any of the following persons:

(A) The parent or parents, including the parent or parents of an unborn child; or

(B) the person who is assigned the primary responsibility for the care and control of the child as one of the following representatives:

(i) A guardian, conservator, or legal custodian; or

(ii) a relative as defined in paragraph (a) (6) of this regulation.

(2) “Child” means a Kansas resident under the age of 19 years.

(3) “Family group” means the applicant or recipient and all individuals living together in which there is a relationship of legal responsibility or a caretaker relationship.

(4) “Filing unit” means all children in the family group who are living with a legally responsible relative and the legally responsible relatives in the family group.

(5) “Legally responsible relative” means the person who has the legal responsibility to provide support for a child in the plan.

(6) “Relative” means any of the following individuals:

(A) Any blood relative who is within the fifth degree of kinship to the child, including any of these relatives:

(i) Parents;

(ii) siblings

(iii) nephews;

(iv) nieces;

(v) aunts;

(vi) uncles; and

(vii) persons of preceding generations who may be denoted by prefixes of grand, great, great-great, or great-great-great;

(B) a stepfather, stepmother, stepbrother, or stepsister;

(C) a legally adoptive parent or parents or another relative or relatives of adoptive parents as noted in paragraphs (6) (A) and (6) (B) above;

(D) a spouse of any person named in the above groups or a former spouse of any of those persons, if marriage is terminated by death or divorce.

(b) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-3. Providers.** Subject to provider availability, any recipient may be required to choose a managed care option in order to access covered program services. (a) Managed care contractors shall be selected by the secretary from willing providers based upon the best interest of the agency, as determined by the secretary or designees using the best professional judgment.

(b) Before signing a contract to provide services, each provider of capitated managed care shall demonstrate the ability to meet contract requirements, including providing or maintaining the following:

(1) Financial solvency;

(2) a panel of service providers, who shall meet these criteria:

(A) Are appropriately credentialed;

(B) are in active practice;

(C) are available to provide services to program enrollees; and

(D) are able to provide services sensitive to the needs of a diverse population, including individuals of any race, ethnicity, or disability;

(3) an approved quality management process; and



(4) other requirements determined by the secretary. In order to participate as a managed care provider, each contractor shall abide by every provision of the contract. Penalties for failure to abide by contract provisions shall be imposed by the secretary, or other appropriate actions, as enumerated in the contract provisions, may be taken.

(c) Each capitated managed care contractor shall be reimbursed at a rate agreed to by the secretary.

(d) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1 and Section 5; effective Nov. 1, 1998.)

**30-14-20. Application process.** (a) Attention given to requests. All applications, inquiries, and requests for healthwave shall be given prompt attention.

(b) Who may file. An application for healthwave shall be made by each applicant or by another person authorized to act on the applicant's behalf.

(c) Applications.

(1) The applicant or person authorized to act on behalf of the applicant shall sign the application. If any person signs by mark, the names and addresses of two witnesses shall be required.

(2) Applications may be submitted by either mail or fax.

(d) Time in which application is to be processed.

(1) Applications for healthwave shall be approved or denied within 15 calendar days of the agency's receipt of a signed application and all supporting documentation, but no later than 45 days from the date the signed application is received.

(2) The 45-day maximum time period may be extended if the application has been withdrawn or if the required determination of eligibility cannot be made within the mandated time period due to the failure of the applicant or a collateral to provide necessary information.

(3) If the agency takes action to deny an application within the 45-day time period and the applicant reapplies or provides required information within the 45-day time period, the application shall be reactivated.

(e) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section

2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-21. Reenrollment process.** (a) Purpose of reenrollment. The purpose of the reenrollment shall be to give the recipient an opportunity to bring to the attention of the agency the recipient's current situation and to give the agency an opportunity to review the factors of eligibility in order to redetermine the recipient's eligibility for coverage under the program.

(b) Acceptance of reenrollment forms. Reenrollment forms may be submitted by either mail or fax.

(c) Frequency of reenrollment. A recipient's eligibility for healthwave shall be redetermined as often as a need for review is indicated. Reenrollment for coverage shall occur at least once each 12 months.

(d) Failure to pay premiums. A recipient shall not be eligible for coverage under the healthwave program if the recipient is subject to the premium payment requirements of K.A.R. 30-14-29 and has failed to pay all premiums due before reenrollment in the program.

(e) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-22.** (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 1; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998; revoked Aug. 11, 2006.)

**30-14-23. Responsibilities of applicants and recipients.** Each applicant or recipient shall meet these requirements: (a) Supply, insofar as the applicant or recipient is able, information essential to the establishment of eligibility;

(b) give written permission for release of information when needed;

(c) report each change in circumstances within 10 calendar days of the change;

(d) meet the applicant's or recipient's own medical needs insofar as that individual is capable; and

(e) cooperate with the agency in obtaining income due the person or any other person for whom the individual is applying for or receiving healthwave.

(f) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997

Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-24. Agency responsibility to applicants and recipients.** (a) The following actions shall be performed by the agency:

(1) On the request of an applicant or recipient, explain the applicant's or recipient's rights and responsibilities; and

(2) inform individuals of the following requirements placed upon the agency;

(A) Periodic redeterminations of eligibility shall be made by the agency.

(B) Investigation and referral for legal action shall be undertaken by the agency regarding any fraudulent application for or receipt of coverage.

(C) Unless otherwise prohibited by law, confidential information shall be disclosed by the agency when the purpose of the disclosure is directly related to any of the following:

(i) The administration of the healthwave program;

(ii) an investigation, or a criminal or civil proceeding being conducted in connection with the administration of the program; or

(iii) the reporting to the appropriate law enforcement officials the intention of an individual to commit a crime.

(b) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-25. General eligibility requirements.** (a) Act in own behalf. Each applicant or recipient shall meet the provisions of K.A.R. 30-6-52.

(b) Citizenship, alienage, and residence. Each applicant or recipient shall meet the provisions of K.A.R. 30-6-54.

(c) Cooperation. Each applicant, recipient, or ineligible caretaker shall cooperate with the agency in the establishment of eligibility. Failure to provide information necessary to determine eligibility shall render the child ineligible for healthwave.

(d) Social security number. Each applicant or recipient shall provide the applicant's or recipient's social security number. Failure to provide the number, or failure to apply for a number if the applicant or recipient has not previously been

issued a number, shall render the applicant or recipient ineligible for coverage.

(e) Living in a public institution. The applicant or recipient shall not be living in a public institution in accordance with K.A.R. 30-6-60.

(f) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-26. Insurance coverage.** (a) The applicant or recipient shall not currently have health insurance coverage to be eligible for the healthwave program.

(b) If not presently covered, the applicant or recipient shall not have had health insurance coverage in the prior six months and terminated this coverage without good cause.

(c) The applicant or recipient shall not be eligible for enrollment in the Kansas group health insurance program.

(d) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-27.** (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998; revoked June 30, 2006.)

**30-14-28. Premium payment requirement.** If the total monthly applicable income in the family group exceeds 150% of the official federal poverty income guidelines, the family shall pay a monthly premium for coverage in the healthwave program. (Authorized by K.S.A. 39-708c and K.S.A. 38-2002; implementing K.S.A. 2001 Supp. 38-2001; effective Nov. 1, 1998; amended, T-30-1-2-03, Jan. 2, 2003; amended April 18, 2003.)

**30-14-29. General rules for consideration of income.** (a) For purposes of determining eligibility for coverage, legal title shall determine ownership. In the absence of legal title, possession shall determine ownership.

(b) Income shall be considered available both when actually available and when the applicant or recipient has the legal access to the income. Income shall be considered unavailable when there is a legal impediment that precludes access to it. The applicant or recipient shall pursue reasonable

steps to overcome the legal impediment, unless it is determined that the cost of pursuing legal action would exceed the value of the total income available or that it is unlikely the applicant or recipient would succeed in the legal action.

(c) The conversion of real or personal property from one form of resource to another shall not be considered to be income to the applicant or recipient, except for the proceeds from a contract for the sale of property.

(d)(1) Nonexempt income of all persons in the assistance plan shall be considered in determining eligibility.

(2) Despite paragraph (d)(1) above, the income of a child whose needs are met through foster care payments shall not be considered in determining eligibility.

(e) The income of an ineligible parent shall be considered in determining the eligibility of a child for the healthwave program if the parent and child are living together.

(f) Despite paragraph (d)(1) and subsection (e) above, the income of an SSI beneficiary shall not be considered in the determination of eligibility for the healthwave program of any other person.

(g) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-30. Applicable income.** "Applicable income" means the amount of earned and unearned income that is compared with the poverty income guidelines referenced in K.A.R. 30-14-27 to establish financial eligibility. (a) Applicable earned income. All earned income shall be considered applicable income unless exempted in accordance with K.A.R. 30-6-112(a) through (bb) and K.A.R. 30-6-113(a) through (r). Applicable earned income shall be determined as follows.

(1) Applicable earned income for persons included in the living unit, and for all persons in the home whose earned income shall be considered and who are excluded from the living unit, shall equal gross earned income, or the adjusted gross earned income from self-employment, less \$200.00 per month for each employed person.

(2) For self-employed persons, adjusted gross earned income shall equal gross earned income less cost of the production of the income. A standard deduction of 25% of gross earned income shall be allowed for these costs. If the person

wishes to claim actual costs incurred, the following guidelines shall be used by the agency in calculating the cost of the production of the income.

(A) The healthwave program shall not treat income on the basis of internal revenue services (IRS) policies and shall not be used to either subsidize the payment of debts or set up an individual in a business or a nonprofit activity.

(B) If losses are suffered from self-employment, the losses shall not be deducted from other income, nor shall the net loss of a business be considered as an income-producing cost.

(c) If a business is being conducted from a location other than the applicant's or recipient's home, the expenses for business space and utilities shall be considered as income-producing costs.

(D) If a business is being conducted from a person's own home, shelter and utility costs shall not be considered as income-producing costs unless the person can verify that those costs are clearly distinguishable from operation of the home.

(E) If payments increase the equity in equipment, vehicles, or other property, the payments shall not be considered as an income-producing cost.

(F) If equipment, vehicles, or other property is being purchased on an installment plan, the actual interest paid may be considered as an income-producing cost.

(G) Depreciation on equipment, vehicles, or other property shall not be considered as an income-producing cost.

(H) Insurance payments on equipment, vehicles, or other property shall be allowed if the payments directly relate to the business.

(I) Expenses for inventories and supplies that are reasonable and required for the business shall be considered as income-producing costs.

(J) Wages and other mandated costs related to wages paid by the applicant or recipient may be considered as income-producing costs.

(b) Applicable unearned income.

(1) All net unearned income shall be considered to be applicable income, unless exempted in accordance with K.A.R. 30-6-112(a) through (bb) and K.A.R. 30-6-113(a) through (r).

(2) Net unearned income shall equal gross unearned income less the costs of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income. The principles set forth in

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paragraph (a) (2) of this regulation regarding the calculation of income-producing costs shall apply. (Authorized by K.S.A. 1998 Supp. 39-708c and 38-2002; implementing K.S.A. 1998 Supp. 38-2001; effective Nov. 1, 1998; amended July 2, 1999.)

**30-14-31. Payment amounts.** (a) Underpayments. Underpayments shall be promptly corrected.

(b) Overpayments. Overpayments may be recovered by voluntary repayment, administrative recoupment, or legal action. Administrative recoupment procedures shall not be initiated by the agency pending the disposition of a welfare fraud referral.

(c) Discontinuance of assistance. Any recipient's participation in the healthwave program shall be discontinued when the recipient no longer meets one or more of the appropriate factors of eligibility.

(d) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**30-14-50. Scope of services.** (a) Services provided to children enrolled in the healthwave program shall be as enumerated at K.A.R. 30-5-87, scope of the Kan Be Healthy program.

(b) This regulation shall take effect on and after November 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c and L. 1998, Chapter 125, Section 2; implementing L. 1998, Chapter 125, Section 1; effective Nov. 1, 1998.)

**Articles 15 to 16.—RESERVED****Article 17.—HOUSING, PROCUREMENT, AND OPERATIONS—COUNTY WELFARE DEPARTMENT**

**30-17-1 and 30-17-2.** (Authorized by K.S.A. 39-708; effective Jan. 1, 1967; revoked May 1, 1978.)

**30-17-3 to 30-17-5.** (Authorized by K.S.A. 1977 Supp. 39-708c; effective Jan. 1, 1967; revoked May 1, 1978.)

**Article 18.—LICENSING OF SOCIAL WORK PERSONNEL**

**30-18-1.** (Authorized by K.S.A. 1978 Supp. 75-5350; effective May 1, 1976; amended Feb. 15,

1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1982.)

**30-18-2.** (Authorized by K.S.A. 1976 Supp. 75-5350; effective May 1, 1976; amended Feb. 15, 1977; revoked May 1, 1982.)

**30-18-3 and 30-18-4.** (Authorized by K.S.A. 1975 Supp. 75-5350; effective May 1, 1976; revoked May 1, 1982.)

**Article 19.—SOUTHEAST KANSAS TUBERCULOSIS HOSPITAL**

**30-19-1.** (Authorized by K.S.A. 1976 Supp. 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1970; amended Jan. 1, 1974; revoked Feb. 15, 1977.)

**30-19-2.** (Authorized by K.S.A. 39-111, K.S.A. 1976 Supp. 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1974; revoked Feb. 15, 1977.)

**30-19-3.** (Authorized by K.S.A. 76-1510; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1971; revoked Feb. 15, 1977.)

**30-19-4.** (Authorized by K.S.A. 76-1510; effective Jan. 1, 1967; amended Jan. 1, 1969; revoked Jan. 1, 1971.)

**30-19-5.** (Authorized by K.S.A. 1976 Supp. 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1974; revoked Feb. 15, 1977.)

**30-19-6.** (Authorized by K.S.A. 1976 Supp. 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1969; revoked Feb. 15, 1977.)

**30-19-7 and 30-19-8.** (Authorized by K.S.A. 1976 Supp. 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1974; revoked Feb. 15, 1977.)

**30-19-9.** (Authorized by K.S.A. 76-1510b; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1970; amended Jan. 1, 1974; revoked Feb. 15, 1977.)

**30-19-10.** (Authorized by K.S.A. 1976 Supp. 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1974; revoked Feb. 15, 1977.)



**Article 20.—SECURITY AND TRAFFIC CONTROL FOR STATE INSTITUTIONS OPERATED BY MENTAL HEALTH AND RETARDATION SERVICES**

**30-20-1 and 30-20-2.** (Authorized by K.S.A. 76-12a16; effective Jan. 1, 1974; revoked May 1, 1982.)

**30-20-3.** (Authorized by K.S.A. 76-12a16; effective Jan. 1, 1974; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1982.)

**30-20-4.** (Authorized by K.S.A. 76-12a07; implementing K.S.A. 76-12a16; effective May 1, 1982; revoked May 1, 1983.)

**30-20-5. Badge.** Security officers shall wear and publicly display a badge clearly identified with the words, “security policeman” and “SRS institution”. The badge shall be worn only while on official duty. The badge shall remain the property of the institution and shall be turned in whenever an appointment as a security officer is terminated. (Authorized by and implementing K.S.A. 76-12a16; effective May 1, 1982.)

**30-20-6. Law enforcement assistance.** The superintendent on an institution may request appropriate law enforcement personnel to assist the security officers in the performance of their official duties as necessary. (Authorized by K.S.A. 76-12a07; implementing K.S.A. 76-12a16; effective May 1, 1982.)

**30-20-7. Traffic and parking control.** (a) The provisions of K.A.R. 30-20-8 through 30-20-19 shall apply to the operation of motor vehicles and bicycles upon state institution grounds except as set forth in paragraph (b) and shall be enforced at all times unless otherwise posted.

(b) Any regulation shall not apply if in conflict with city ordinances or state laws effective on state institution grounds. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12, 76-12a14; effective May 1, 1982.)

**30-20-8. Superintendent responsibilities.** (a) The superintendent of an institution shall adopt policies concerning speed limits, the routing of traffic movement, and parking on institution grounds. Regulatory, warning, and guide signs shall be posted as appropriate.

(b) Subject to the provisions of paragraphs (c) and (d), the superintendent of an institution may:

(1) Require the registration of motor vehicles regularly operated on institutional grounds;

(2) Require parking permits;

(3) Charge parking fees for the regular use of parking spaces; and

(4) Allocate specific parking spaces to employees or other individuals.

(c) Parking fees shall be approved by the commissioner and secretary.

(d) Parking permits shall be valid for the current fiscal year subject to the permit holder terminating his or her connection with the institution. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12, 76-12a15; effective May 1, 1982.)

**30-20-9. Rules of the road.** The rules of the road set forth in chapter eight (8) of the Kansas statutes annotated (effective July 1, 1982) shall apply to state institution grounds unless otherwise posted or in conflict with other provisions of this article. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982; amended May 1, 1983.)

**30-20-10. Maximum speed limit.** The maximum speed limit shall be twenty-five miles per hour (25 mph) unless otherwise posted. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982.)

**30-20-11. Buses.** Buses shall have the right-of-way over other motor vehicles and bicycles except for emergency vehicles displaying the appropriate signals. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982.)

**30-20-12. Maintenance vehicles and equipment.** Maintenance vehicles and equipment shall be exempt from the guide and parking provisions of this article if the exemption is necessary for maintenance purposes. If exempted, vehicles and equipment shall be operated and parked with a minimum of traffic obstruction or hazard. Proper warning and safety devices shall be used as appropriate. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982.)

**30-20-13. Movement of heavy equipment.** Heavy equipment may only be operated on state institution grounds if supervised by the institution's maintenance personnel or security of-

ficers. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982.)

**30-20-14. Accidents, collisions, fire, or theft.** Accidents, collisions, fires, or thefts involving motor vehicles or bicycles shall immediately be reported to the state institution's security office. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982.)

**30-20-15. Prohibited acts.** The following acts shall be prohibited and subject to fine: (a) Violation of any administrative regulation set forth in this article;

(b) Failure to follow any regulatory, warning, or guide sign;

(c) Failure to display a registration or parking permit if required;

(d) Double parking;

(e) Transporting of unauthorized firearms or other weapons, explosives, drugs, or alcohol upon state institution grounds; and

(f) Failure to follow directions of a security officer or other law enforcement official. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982.)

**30-20-16. Fines.** Persons ticketed shall be subject to the following fines: (a) Non-moving violation not involving creation of a danger or hazard—ten dollars (\$10);

(b) Non-moving violation involving creation of a danger or hazard—twenty dollars (\$20);

(c) Moving violation involving the failure to follow any regulatory, warning, or guide sign—twenty dollars (\$20);

(d) Failure to follow directions of a security officer or other law enforcement officer—thirty dollars (\$30);

(e) Transporting of unauthorized fire arms or other weapons, explosives, drugs, or alcohol upon state institution grounds—one hundred dollars (\$100);

(f) Failure to display a registration or parking permit if required—ten dollars (\$10); and

(g) Other violations—ten dollars (\$10). (Authorized by and implementing K.S.A. 76-12a13; effective May 1, 1982.)

**30-20-17. Review by superintendent.** (a) Any person ticketed may request the superintendent to dismiss or amend a ticket within ten (10) days of its issuance.

(b) The superintendent or his or her designee shall conduct an informal review concerning the

request within twenty (20) days of its receipt. A person ticketed shall be given an opportunity to be heard on the question, to put forth evidence, and to cross-examine the ticketing officer.

(c) The decision of the superintendent or his or her designee shall be in writing and shall set forth the underlying facts supporting its conclusions and shall be final. (Authorized by and implementing K.S.A. 76-12a13; effective May 1, 1982.)

**30-20-18. Failure to pay fine.** (a) Any person failing to pay a fine within ten (10) days of being ticketed shall be prohibited from operating any motor vehicle or bicycle upon state institution grounds until the fine is paid. This provision shall not bar the institution from using other legal remedies to collect unpaid fines.

(b) If a person ticketed appeals the ticket pursuant to K.A.R. 30-20-17, the provisions of this regulation shall be stayed pending the outcome of the review. (Authorized by and implementing K.S.A. 76-12a13; effective May 1, 1982.)

**30-20-19. Removal of vehicles, bicycles.** Vehicles or bicycles may be removed from the institution's grounds if allowed to stand in violation of any regulation or if left in a position or condition to constitute a hazard to the safety of others. The cost of same shall be paid by the owner of the vehicle or bicycle. (Authorized by K.S.A. 76-12a13; implementing K.S.A. 76-12a12; effective May 1, 1982.)

## Article 21.—TRAFFIC AND PARKING

**30-21-1 to 30-21-19.** (Authorized by K.S.A. 76-12a13; effective Jan. 1, 1974; revoked May 1, 1982.)

## Article 22.—LICENSING OF PSYCHIATRIC HOSPITALS; FUNDING OF COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED AND FACILITIES FOR HANDICAPPED PERSONS

**30-22-1. Scope.** (a) These rules and regulations shall apply to the licensing of psychiatric hospitals as authorized by K.S.A. 75-3307b, as amended, and shall apply to the setting of standards, the inspection of such hospitals, and the withdrawal of licenses for cause.

(b) Terms used herein shall have the same

meaning as defined in the “act for obtaining treatment for a mentally ill person,” K.S.A. 59-2901 through 59-2941, as amended. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Feb. 15, 1977; amended May 1, 1979; amended Oct. 28, 1991.)

**30-22-2. Principles to be considered in approval of application for licensing, renewal of license, or revoking of license.** The following principles shall be considered in the inspection of the applying psychiatric hospital: (a) The quality of the services offered by the applying agency is determined by professional standards, and the selection of the services as to kind and extent can only be determined by the governing authority usually based upon the will of the community, the nature of the community problems, and the depth of community resources (acting together with the professional considerations).

(b) The applying agency shall be a growing, developing, social organization with different stages of differentiation and versatility dependent upon the specific local internal and community forces acting at a given point in time.

(c) Services of the applying agency may be offered to the mentally ill, the mentally retarded, persons under specific or unusual stress, or handicapped persons. Services may include those listed below offered either in an inpatient, residential setting, or an outpatient, neighborhood, or home setting.

(1) Diagnosis, evaluation, treatment, and restoration of mentally disordered or handicapped persons to an optimal level of functioning.

(2) Day care, training, education, sheltered employment necessary to improve an individual's maximum abilities leading toward total rehabilitation.

(3) Consultative and educational services to schools, courts, health and welfare and social agencies, both public and private.

(4) Training for students entering the mental health and retardation professions and continuing inservice training of mental health and retardation professionals and adjunctive personnel.

(5) Recruitment, training, and supervision of volunteer workers in the mental health related activities of the community.

(6) Informational activities directed toward the general population.

(7) Research.

(8) Interventions in society purposely directed to reduce stresses to the individual or to the community as a whole, which stresses contribute to the incidence of mental illness or mental retardation.

(9) Client information and referral, counseling, follow along, protective and other social and socio-legal services, transportation, residential and transitional centers, and recreation services, all geared toward the handicapped individuals, their families and the general public.

(d) The applying agency shall acknowledge the dignity and protect the rights of all persons within its authority to direct or regulate both personnel and clientele.

(e) The applying agency shall have an ethical and competent staff, and the recruitment practices shall provide measures to insure the hiring of personnel with these characteristics.

(f) The applying agency shall make provisions to cooperate with other community agencies within the scope of its resources and the skills of its personnel, and within its capacities to respond to the community needs.

(g) The applying agency shall keep accurate, current, and adequate client and administrative records, and shall submit reports derived from such records as required by the licensing agency to carry out these licensing procedures.

(h) The applying agency shall have written policies and procedures covering operation of the agency, including a written policy on how the agency is related to the statewide mental health planning effort.

(i) The applying agency shall provide a physical plant which is a safe and wholesome environment fit to enhance the program.

(j) The applying agency shall plan the program and physical plant to be accessible to clientele in point of view of time, location, and transportation. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended May 1, 1979; amended Oct. 28, 1991.)

**30-22-3. Standards related to program, organization, and personnel.** The standards maintained by the applying agency should conform with those considered reasonable and current in the community served by that agency. Also, separate segments of the program must be evaluated not only in terms of its own intrinsic

value to the community but also in terms of its relationship to the total program of that agency. The standards maintained by the applying agency should be reflected in its basic documents, including its articles of incorporation or constitutions, its by-laws, its recorded minutes of regularly scheduled meetings, and its written description of personnel practices. The following guidelines will be followed by the licensing agency in its inspection of the applying agency: (a) The applying agency must specify in writing the services it offers and the manner in which these are routinely accomplished.

(b) The applying agency must make provision for appropriate coordination, communication and collaboration among all personnel.

(c) The governing board must assume the legal and moral responsibility for the conduct of the applying agency. It must place the responsibility for the services offered upon the appropriate specialist, must assume the responsibility that the personnel meet ethical, educational, and training standards commensurate with duties, and must provide a merit system for the protection and benefit of the personnel.

(d) The governing board must assume the responsibility to insure that those functions of the agency that are, properly speaking, medical concerns (such as the diagnosis and treatment of mental and physical disorders, the prescribing of medications, etc.) are the responsibility of licensed physicians or under the supervision of a licensed physician.

(e) In the event the applying agency maintains a psychiatric service, the service shall not be considered complete unless supervised by a recognized, qualified psychiatrist.

(f) In the event the applying agency maintains a psychological service, the service shall not be considered complete unless supervised by a recognized, qualified psychologist.

(g) In the event the applying agency maintains a social work service, the service shall not be considered complete unless supervised by a recognized, qualified social worker.

(h) In the event the applying agency maintains a nursing service, the service shall not be considered complete unless supervised by a recognized, qualified registered nurse.

(i) Any individual reporting to act in a professional capacity must meet the standards for that profession accepted by the division of mental health and retardation services. (Authorized by

K.S.A. 1974 Supp. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended May 1, 1975.)

**30-22-3a. Private psychiatric hospitals; additional organizational standards.** Each hospital shall: (a) Have a governing body that has overall responsibility for the operation of the hospital;

(b) have a chief executive officer appointed by its governing body who shall be responsible for the overall administration of the hospital;

(c) have a single, organized professional staff that has the overall responsibility for the quality of all clinical care provided to patients and for the professional practices of its members, as well as for accounting therefor to the governing body. The manner in which the professional staff is organized shall be consistent with the hospital's documented staff organization and bylaws, policies, and the setting in which the services are provided. The professional staff bylaws, rules and regulations shall require, unless otherwise provided by law, that a licensed physician be responsible for diagnosis and all medical care and treatment. The organization of the professional staff, and its bylaws, rules and regulations, shall be approved by the governing body;

(d) prepare a written, annual budget which includes a statement of expected revenues and expenses and an integrated statement of the hospital's progress plan;

(e) have personnel policies which promote its objectives and provide qualified personnel during all hours of operation in numbers which are adequate to support the functions of the hospital and to provide quality care;

(f) provide staff development programs for administrative, professional, and support staff; and

(g) make library services available to meet the professional and technical needs of the facility's staff. (Authorized by and implementing K.S.A. 75-3307b, effective May 1, 1985.)

**30-22-3b. Private psychiatric hospitals; additional program standards.** Each hospital shall: (a) Formulate and specify its goals and objectives and describe its programs (including volunteer services, if any) in a written plan for professional services. The plan shall be written in such a manner that the hospital's performance can be measured;

(b) have a written statement of goals and ob-



jectives for each program and each patient population served;

(c) conduct a utilization review program;

(d) exhibit evidence of a well-defined, organized program designed to enhance patient care through ongoing, objective assessment of important aspects of patient care and correction of identified problems; and

(e) if conducting research with human subjects, have written policies which assure that a rigorous review is conducted with regard to the merits of each research project and the potential effects of the research procedures on the participants. (Authorized by and implementing K.S.A. 75-3307b; effective May 1, 1985.)

**30-22-3c. Private psychiatric hospitals; additional treatment standards.** Each hospital shall: (a) Maintain a written record for each patient;

(b) have a written plan designed to assure that the treatment planned and provided for each patient is evaluated and revised according to the needs of the patient;

(c) have written policies and procedures governing the intake process which specify the following:

(1) The information to be obtained for each applicant or referral for admission;

(2) the procedures for accepting referrals from outside agencies and organizations;

(3) the records to be kept regarding each applicant;

(4) the statistical data to be kept on the intake process; and

(5) the procedures to be followed when an applicant or a referral is found to be ineligible for admission;

(d) conduct a complete assessment of each patient, including a clinical consideration of the patient's needs;

(e) develop a written, individualized treatment plan for each patient. The plan shall be based on an assessment of such patient's clinical needs;

(f) require special, written justification prior to the implementation of the following treatment procedures:

(1) The use of restraints;

(2) the use of seclusion;

(3) the use of electroconvulsive therapy and other forms of convulsive therapy; and

(4) the performance of psychosurgery or other surgical procedures for intervention in or altera-

tion of a mental, emotional, or behavioral disorder; and

(g) assess and treat the dental needs of its patients. (Authorized by and implementing K.S.A. 75-3307b; effective May 1, 1985.)

**30-22-3d. Private psychiatric hospitals; additional services.** (a) Each hospital shall provide the following services except as noted:

(1) Dietetic services, if a hospital provides 24-hour care, has therapeutic goals related to the nutritional needs of patients, or has patients otherwise requiring such services;

(2) pastoral services, in accordance with the needs of its patients;

(3) pathology and laboratory services, in accordance with the needs of the patients, the size of the facility, the services offered, and the resources available in the community;

(4) pharmaceutical services provided by the hospital or by agreement; and

(5) radiology services provided by the hospital or by agreement.

(b) In addition to the services listed in subsection (a), inpatient, residential and partial-day facilities shall directly provide or make arrangements for the following services:

(1) Activity services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of patients;

(2) educational services to meet patient needs for special education, patient needs related to learning difficulties resulting from either physical or emotional aspects of their mental illness, and patient needs for pre-vocational or vocational education necessary for re-integration into the community after treatment;

(3) speech-language, and hearing services to provide assessments of speech, language, or hearing when indicated and to provide counseling, treatment, and rehabilitation when needed; and

(4) counseling services concerning specific vocational needs. (Authorized by and implementing K.S.A. 75-3307b; effective May 1, 1985.)

**30-22-4. Standards related to physical**

**plant.** The applying agency shall provide a physical plant which is a safe and wholesome environment fit to enhance the program. With particular programs directed to special groups of the emotionally or mentally handicapped much attention may have to be expended on the environmental atmosphere and appearance to make the milieu stimulating or calming, diverting, focusing, infor-

mal or formal as the care and treatment program demands. To this end, the plant shall have differentiated rooms and spaces appropriate to the programs being offered. However the physical plant shall meet all local building and fire codes and also state requirements for use by physically handicapped persons where appropriate. (Authorized by K.S.A. 1974 Supp. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended May 1, 1975.)

**30-22-4a. Private psychiatric hospitals; additional environmental management standards.** (a) Each building in which patients receive treatment or in which patients are housed overnight shall be designed, constructed, and equipped to reasonably protect patients, staff, and visitors from the hazards of fire, explosion, and panic.

(b) Each hospital shall:

(1) Establish a safety committee that includes representatives from all major services;

(2) establish an environment that enhances the positive self-image of patients and preserves their human dignity;

(3) develop written policies and procedures for maintaining a clean and safe environment;

(4) develop an infection-control program; and

(5) develop written policies and procedures for the handling, maintenance, and use of sterile supplies and equipment if such supplies and equipment are used by the hospital. (Authorized by and implementing K.S.A. 75-3307b; effective May 1, 1985.)

**30-22-5. Licensing of private psychiatric hospitals.** Private in-patient facilities for the treatment of psychiatric patients exclusively may be licensed to offer services to the full range of psychiatric patients or to some sub-groups of psychiatric patients with mental health problems in addition to alcoholism, drug addictions, developmental disabilities or similar conditions. In the event that a hospital service is offered to a limited clientele only, the license application shall so state and the license issued shall designate the limitation of service authorized by the state department of social and rehabilitation services. The responsibility for licensing psychiatric wards of general hospitals rests with the Kansas state department of health and environment. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended

Feb. 15, 1977; amended May 1, 1979; amended Oct. 28, 1991.)

**30-22-6. Licensing procedure; duration and renewal of license.** (a) Each application for a license shall be submitted to the director of the division of mental health and retardation services on a form provided by the department.

(b) The division shall process the application, inspect the applying agency, and prepare a report to the director. The director shall review the report and recommend approval or disapproval of the application within 60 days of filing.

(c) Upon approval of the application, a license shall be issued by the department of social and rehabilitation services, stating the activity or activities for which the applicant receives the license.

(d) A license shall remain in effect for the period of two years, unless revoked for cause.

(e) Application for renewal of a license shall be submitted to the director of the division of mental health and retardation services 45 days before expiration of the license. This provision may be waived by the director upon a showing of good cause by the agency. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979; amended Oct. 28, 1991.)

**30-22-7. Revocation of license.** A license may be suspended or revoked at any time that the department of social and rehabilitation services finds that the licensed agency has failed to comply with these regulations or applicable statutes. Prior to suspension or revocation of an agency's license, the division of mental health and retardation services shall send to the agency a written notification of the proposed suspension or revocation and the reasons therefor. The notice shall state whether the agency's license has been suspended pending further proceedings. Such notice shall further advise the agency that the agency may appear before the division at a specified time not less than five (5) nor more than fifteen (15) days from the date the notice is mailed to or served upon such agency and present any relevant evidence and be given an opportunity to be heard on the agency's continuing eligibility to be licensed. The division shall consider all evidence presented, including that of the agency. If the decision is to suspend or revoke the agency's license as herein provided, the division shall issue a written order of suspension or revocation setting forth the effective date of such

suspension or revocation and the basic underlying facts supporting the order. (Authorized by K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979.)

**30-22-8. Compliance with civil rights legislation.** Each agency licensed or applying for license by the department of social and rehabilitation services shall comply with the Kansas act against discrimination. (Authorized by K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979.)

**30-22-9. Provisional license.** A provisional license to begin operations or continue operations may be issued to an agency meeting most but not all of the requirements, provided the governing board of the agency presents evidence that any deficiency is temporary and provided said governing board presents sufficient evidence that efforts to correct the deficiency are in progress. (Authorized by K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971.)

**30-22-10.** (Authorized by K.S.A. 65-4406(c); implementing K.S.A. 65-4404(b); effective May 1, 1975; amended May 1, 1979; amended May 1, 1981; amended May 1, 1983; amended, T-86-26, Aug. 19, 1985; amended May 1, 1986; revoked May 1, 1987.)

The content of this regulation is being transferred to 30-22-30 effective May 1, 1987.

**30-22-11 to 30-22-14.** (Authorized by K.S.A. 75-3304, K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; implementing K.S.A. 19-4001, K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1987; revoked Oct. 28, 1991.)

**30-22-15 to 30-22-28.** (Authorized by K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1987; revoked Oct. 28, 1991.)

**30-22-29. Reserved.**

**30-22-30. Application for state financing of community mental health centers.** (a) Community mental health centers may apply for state financing under L. 1987, Ch. 249, Sections 1 through 12 by submitting an annual budget request to the secretary of social and rehabilitation services.

(b) Budget requests shall be submitted to the secretary by July 1 of each year unless a delay is granted in writing.

(c) Budgets shall be submitted on forms and according to instructions prescribed by the secretary.

(d) When an existing program is adequately serving a geographic area, a duplicate program shall not be requested in the budget of a center. Reasonable efforts shall be made to make the existing service available to all citizens in the area through contractual agreement with the provider of the existing service, if necessary.

(e) When a new program is to be implemented by a center, the center must notify the secretary 45 days in advance of program initiation in order to receive approval as a non-duplicate program in the center catchment area. In determining whether a new program duplicates an existing program, the secretary will consider pre-existing programs in the center catchment area and the availability of the pre-existing programs to all groups of catchment area citizens.

(f) As soon as state appropriation bills are signed into law, the amount available for each center that has submitted a budget shall be determined by the secretary. The amount shall be equal to the amount that the center's average grant would have been under the Kansas community mental health assistance act for the fiscal years ending on June 30, 1986, June 30, 1987, and June 30, 1988, if such act had not been repealed and if appropriations for the fiscal year ending June 30, 1988 to finance grants under such act had remained constant from the previous fiscal year plus each mental health center's pro rata share of any increase in moneys, including any inflation adjustments, appropriated for such purpose. The amounts so determined shall be paid to the centers in four payments on July 1, October 1, January 1 and April 1.

(g) Each center shall submit a quarterly report within 30 working days after the end of each calendar quarter. The report shall be on forms and in such detail as prescribed by the secretary.

(h) Each center shall file a copy of its annual audit report that has been certified by an independent auditor.

(i) Underpayments, overpayments or payments exceeding the maximum allowed by statute shall be subtracted from or added to the payment made on April 1.

(j) The secretary may withdraw funds from any center for one or more of the following reasons:

(1) not being substantially administered according to the annual budget;

(2) loss of license granted in accordance with the provisions of K.S.A. 75-3307b and amendments thereto; or

(3) net loss in a new program which did not receive approval by the secretary and which is found to be a duplicate program within the center catchment area. The secretary shall verify the amount of income and disbursements related to such programs in determining any net loss with audits conducted by auditors of the department of social and rehabilitation services. The amount withdrawn will be equal to the net loss of the program determined after each 12 months of operation.

(k) The secretary may withhold payments from a center or facility for one or more of the following reasons:

(1) Failure to submit required reports;

(2) unreasonable delay in the submission of required reports; or

(3) other good cause.

(l) Quarterly payments described in subsection (e) will be made to a new or realigned community mental health center catchment area only after each new or realigned catchment area has been approved in accordance with K.A.R. 30-22-13 and 30-22-14. The financial plan required in K.A.R. 30-22-13(c)(6) shall include a new or revised budget as required in subsection (c).

(m) Special purpose grants may be awarded by the secretary if appropriated by the legislature for that purpose. The secretary shall consider legislative intent and identified local needs in awarding such grants. (Authorized by L. 1987, Ch. 249, Sec. 12; implementing L. 1987, Ch. 249, Sections 1 through 11; effective May 1, 1987; amended, T-88-42, Oct. 27, 1987; amended May 1, 1988.)

**30-22-31. Definitions.** The following definitions apply to K.A.R. 30-22-32. (a) "State hold harmless level" means the amount appropriated for state fiscal year 1986 under the provisions of K.S.A. 1988 Supp. 65-4411 et. seq., and is comprised of the aggregate of each eligible center's hold harmless level.

(b) "Center's hold harmless level" means the amount a center earned in state fiscal year 1986 under the provisions of K.S.A. 1988 Supp. 65-4411 et. seq.

(c) "Part day" means any adult day activity or vocational programming service that requires at least 1.5 but no more than 3.0 hours of direct contact between a center's staff and its client.

(d) "Full day" means any adult day activity or vocational programming service that requires in excess of 3.0 hours of direct contact between a center's staff and its client.

(e) "Individual habilitation plan (IHP)" means a plan, in written form, which:

(1) Describes a specific strategy for treatment/habilitation developed and agreed upon by team members and the client or a legal representative; and

(2) includes information regarding assessment, goals and objectives, time lines, program strategies and interventions, monitoring, review and documentation procedures.

(f) "Full-day equivalency" means two part-day activity or vocational program units or one full-day activity or vocational program unit.

(g) "Per diem rate" means an amount per program unit that shall be paid to community mental retardation centers for serving mentally retarded, or otherwise developmentally disabled clients.

(h) "Program unit" means either a full-day equivalency in a day program defined in subsections (i) through (n), or placement in community living defined in subsections (o) and (p). No more than two units can be generated for one client on a given day, regardless of the level of disability of the client and the length or intensity of the program provided.

(i) "Adult day care" means programs for elderly or disabled adults to:

(1) Prevent institutionalization or re-institutionalization;

(2) allow individuals to remain in their own home or the least restrictive environment;

(3) protect against abuse, neglect, and exploitation; and

(4) enable family members to obtain or remain in employment.

(j) "Adult life skills training" means programs that provide training in life skills, personal social adjustment and work attitude and skills exploration to improve, maintain functions, or reduce regression of disabled individuals with very limited personal, social, and pre-vocational skills.

(k) "Work activity" means programs that provide long-term instruction and supervision to assist disabled individuals, demonstrating pre-vocational skills, in maximizing vocational abilities.



(l) "Work adjustment" means programs that assist disabled persons, who demonstrate basic work skills, to develop or refine critical work behaviors within a short period of time. These services shall improve the disabled person's prospect of obtaining employment.

(m) "Occupational skills training" means programs that assist disabled persons, who demonstrate a potential to benefit from skill training, to acquire occupational skills needed to perform jobs in competitive employment.

(n) "Supported employment" means programs that provide competitive community employment with emphasis on structural job placement or on-the-job training for as long as is necessary and provides follow-up services that assure continued employment.

(o) "Group living" means residential programs that improve life skills, personal and social adjustment of disabled individuals, needing daily non-medical residential supervision and support, to enable them to become more self-sufficient in the community.

(p) "Semi-independent living" means residential programs that enable disabled individuals, requiring less than daily supervision or training, to remain and function in the community with minimal supervision or training.

(q) "Waiting lists" means a single listing of all persons who have, through an admissions screening process, been found appropriate for and in need of programming that the licensed community mental retardation center should provide for persons with similar disabilities. The effective date of this regulation shall be January 1, 1990. (Authorized by and implementing K.S.A. 1988 Supp. 65-4411 to 65-4415; effective May 1, 1987; amended Jan. 1, 1990.)

**30-22-32. Application for state financing of community mental retardation centers under the community mental retardation centers assistance act.** Recognized community mental retardation centers may apply for state financing by submitting a report to the secretary of social and rehabilitation services (SRS) which indicates the number of program units generated by eligible clients actively enrolled in the center or contracted affiliates on December 31st of each year. (a) Client eligibility. A client shall be eligible and shall generate program units for a center if the client meets the following conditions:

(1) Is mentally retarded, or otherwise developmentally disabled;

(2) is 18 years of age or older;

(3) has an individual habilitation plan (IHP) acceptable by the SRS area office;

(4) is not being supported in whole or in part by a special grant from SRS to support clients transferred from a state hospital or training center, private ICF/MR, or from community waiting lists;

(5) is accepted for a program by the facility on a "first-come, first-serve basis in order of the time at which an application for admission was made to such facility on behalf of the client, except that a client accepted for a program by a facility on other than a first-come, first-serve basis because of a family crisis occasioned by family circumstances shall constitute a full-time equivalent client." A family crisis occasioned by family circumstances shall be considered on an individual basis. Standards and guidelines shall be established by each agency board of directors and shall upon request of the secretary be made available for review by the secretary. The standards and guidelines established by the agency board of directors shall specify to the extent known the types of family crises most likely to necessitate admission to a facility and shall establish criteria for determining the appropriateness of such admission. Standards and guidelines for defining family crises shall specify family situations which make it impossible or extremely difficult for the family unit to provide or continue provision of that care and programming which the client needs based on the client's current behavior, functioning and medical needs. Age, health, transportation and financial capabilities of responsible family members, as well as client needs, shall be valid considerations in determining crises situations;

(6) is not being funded in a certified ICF/MR operated by the center; and

(7) is served by a recognized community mental retardation center or contracted affiliate.

(b) Program eligibility. The following programs as defined in K.A.R. 30-22-31 shall be eligible for generating state financing when provided to an eligible client:

(1) Adult day care;

(2) adult life skills;

(3) work activity;

(4) work adjustment;

(5) occupational skills training;

(6) supported employment;

- (7) group living; and
- (8) semi-independent living.

The center shall be restricted to programs (1) through (8) in computing program units, but shall not be restricted to programs (1) through (8) in expending the grant funds they receive.

(c) Contracts between community mental retardation centers and other providers. Contracts between community mental retardation centers and other providers shall define an unmet program need, and shall be subject to the approval of the secretary of SRS before any state grants shall be awarded.

(d) Per diem calculations. A per diem will be calculated using the following method:

(1) By June 1 of each year, the amount of grant which is held harmless (\$5,216,286) will be subtracted from the total amount of the grant appropriated for the fiscal year beginning July 1.

(2) The resulting amount will be divided by the total number of program units reported by all of the centers for December 31st of the previous year.

(e) Center awards. The per diem will be multiplied by the total number of program units for each center. This amount will be added to the hold harmless grant for each center. The sum of these amounts will constitute the total grant award to be made to each center for the following fiscal year.

(f) Hold harmless distribution. There are established two mechanisms for distributing the state appropriation subject to the hold harmless levels defined in K.A.R. 30-22-31.

(1) If in the event an appropriation meets or exceeds the state's hold harmless level, the grant for a center will be determined by subsection (e).

(2) If in the event the appropriation is less than the state's hold harmless level, then each center shall receive a grant award that is prorated based upon the percentage that each center's hold harmless level comprises the state's hold harmless level.

(g) Annual and quarterly reports. Each center and affiliate shall submit an annual report within 120 working days after the end of the state fiscal year. The center and affiliate shall also submit quarterly reports within 45 days after the close of the quarter. The annual and quarterly reports shall:

(1) Be on forms and in such detail as prescribed by the secretary;

(2) describe by program their income, expenditures, clients and program units; and

(3) include the number and names of clients on their waiting lists.

(h) Annual audit reports. Each center shall file a copy of its annual audit report certified by an independent auditor to social and rehabilitation services, mental health and retardation services.

(i) Audits. Program units reported on the state grant application shall be verified by auditors of the department of social and rehabilitation services.

(j) Underpayments or overpayments. Underpayments or overpayments resulting from audit reports or corrections to prior quarterly reports, shall be subtracted from or added to the payments made on October 1 and April 1.

(k) Withdrawal of funds. Funds may be withdrawn from any center that:

(1) Does not maintain eligibility;

(2) is not being substantially administered according to the grant application, including providing fewer than 95% of the number of program units upon which the center's grant was awarded. In the event a center provides fewer than 95% of the number of program units in the center's grant award, the secretary may calculate the amount to be withdrawn according to the per diem rate multiplied by the number of program units short of the grant award.

(l) Proration of withdrawn funds. If in the event the grant was reduced, withdrawn funds shall be prorated to the other centers according to the method described in subsection (e), and shall be distributed in the April 1 payment.

(m) Appeal of withdrawn funds. Centers may appeal to a review board any withdrawn funds if there are extenuating circumstances that caused them to provide fewer than 95% of the program units in their grant award. Extenuating circumstances include unforeseen changes in funding or client caseload, or unpredictable disasters. The review board shall be comprised of four individuals, two selected by the secretary and two selected by the Kansas association of rehabilitation facilities.

(n) Withholding of payments. The secretary may withhold payments from a center for one or more of the following reasons:

(1) Failure to submit required reports;

(2) unreasonable delay in the submission of required reports; or

(3) failure to enter into an affiliate agreement with a center in order to avoid duplication. The

effective date of this regulation shall be January 1, 1990. (Authorized by and implementing K.S.A. 1988 Supp. 65-4411, 65-4412, 65-4413, 65-4414, 65-4415; effective May 1, 1987; amended May 1, 1988; amended Jan. 1, 1990.)

**30-22-33. Special purpose grants to community mental retardation centers.** (a) Community mental retardation centers may receive special purpose grants from the secretary of social and rehabilitation services or the secretary's designee. These grants are for the purpose of expanding the availability of non-institutional services for persons with mental retardation/developmental disabilities. These grants are distinct from the state financing provided under provisions of K.A.R. 30-22-32.

(b) Grants subject to appropriations. The total funds disbursed by the secretary in accordance with these regulations shall not exceed the amount appropriated.

(c) General eligibility for grants. Only community mental retardation centers having been established pursuant to K.S.A. 19-4001 to 19-4015 inclusive, or agencies with affiliation agreements with these centers that have been approved by the secretary or the secretary's designee, and that have been licensed in accordance with the provisions of K.S.A. 75-3307b shall be eligible to receive special purpose grant funding. Providers that have not been established pursuant to K.S.A. 19-4001 to 19-4015, but have been licensed in accordance with the provisions of K.S.A. 65-501 instead of K.S.A. 75-3307b, may also receive special purpose grant funding if services offered by these providers allow the diversion or discharge of persons 18 years or less from state mental retardation hospitals.

(d) Application for funds. Eligible centers shall apply to the secretary or the secretary's designee to receive special purpose grant funding. Applications must be submitted in a manner prescribed by the secretary or the secretary's designee and must be submitted by the date and time specified by the secretary or the secretary's designee.

(e) Calculation of assistance. Centers may receive assistance on the basis of a written commitment by the center to provide eligible programs, as defined in K.A.R. 30-22-32, to eligible clients, as defined in K.A.R. 30-22-32. Eligible providers may receive assistance in accordance with the provisions of the mental health and retardation serv-

ices commissioner's letter on supported family living.

(1) Funds may be awarded to centers on the basis of the number of eligible program units, as defined in K.A.R. 30-22-32, that are proposed to be provided by the center during the fiscal year for which the grant is awarded. For newly awarded grants, program units must be in addition to the number of total units provided during the preceding fiscal year. For continuation grants initially awarded in previous years, the number of program units may equal the number of units funded by the grant in the previous fiscal year. This unit number is in turn multiplied by the program unit per diem rates established by the secretary or the secretary's designee. For new grants, centers may receive start-up funds in addition to those awarded for provision of program units to allow purchase of necessary materials, supplies and equipment.

(2) If the appropriation is insufficient to fund the cumulative number of program units proposed to be provided by all eligible centers, eligible centers may receive funding on the basis of the percentage of the state's population included within the center's catchment area and the percentage of the statewide total number of program units not funded by the special purpose grants or medicaid that are provided by the respective center.

(3) If the center fails to provide the number of program units on which the grant award was based, the center will be required to return a prorated amount of special purpose grant funding to social and rehabilitation services.

(f) Grant agreement. Additional requirements not specified in regulation may be imposed upon the centers receiving special purpose grant funding. These requirements may be contained in a contractual agreement between the center and social and rehabilitation services. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 75-5321; effective Aug. 1, 1990.)

**Article 23.—PARSONS STATE HOSPITAL  
AND TRAINING CENTER, WINFIELD  
STATE HOSPITAL AND TRAINING  
CENTER, NORTON STATE HOSPITAL  
AND KANSAS NEUROLOGICAL  
INSTITUTE**

**30-23-1.** This rule and regulation shall be revoked on and after December 29, 1995. (Au-

thorized by K.S.A. 1974 Supp. 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-2.** (Authorized by K.S.A. 39-111, K.S.A. 1974 Supp. 76-12a07; effective Jan. 1, 1967; revoked May 1, 1975.)

**30-23-3.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979; revoked Dec. 29, 1995.)

**30-23-4.** (Authorized by K.S.A. 1974 Supp. 76-12a07; effective Jan. 1, 1967; revoked May 1, 1975.)

**30-23-5.** (Authorized by K.S.A. 1974 Supp. 76-17c02; effective Jan. 1, 1967; revoked May 1, 1975.)

**30-23-6.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 76-12a07, 76-17c02; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-7.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 76-12a07, 76-17c02; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-8.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 76-12a07, 76-17c02; implementing K.S.A. 76-12a06; effective Jan. 1, 1967; amended May 1, 1975; amended May 1, 1984; revoked Dec. 29, 1995.)

**30-23-9.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 76-12a07, 76-17c02; effective Jan. 1, 1967; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-10.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 76-12a07, 76-17c02; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-11.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 76-12a07, 76-

17c02; effective Jan. 1, 1967; amended Jan. 1, 1974; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-12.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 76-12a07, 76-17c02; effective Jan. 1, 1967; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-13.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 76-12a07, 76-17c02; effective Jan. 1, 1967; amended Jan. 1, 1970; amended Jan. 1, 1974; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-14.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 75-3304, 76-1411, 76-1617, 76-17c02; effective Jan. 1, 1967; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-15.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 75-3304; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1974; amended May 1, 1975; revoked Dec. 29, 1995.)

**30-23-16.** (Authorized by K.S.A. 1974 Supp. 75-3304; effective Jan. 1, 1969; amended Jan. 1, 1974; revoked May 1, 1975.)

**30-23-17.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1974 Supp. 75-3304; effective May 1, 1975; revoked Dec. 29, 1995.)

#### Article 24.—KANSAS TREATMENT CENTER FOR CHILDREN

**30-24-1 to 30-24-18.** (Authorized by K.S.A. 76-17b01, 76-17b02, 76-17b03; effective Jan. 1, 1967; revoked Jan 1, 1969.)

#### Article 25.—STATE YOUTH CENTERS OPERATED BY SOCIAL AND REHABILITATION SERVICES

**30-25-1.** (Authorized by K.S.A. 76-12a07; effective May 1, 1976; revoked May 1, 1983.)

**30-25-2. Persons eligible for admission to a state youth center.** Juveniles 13 years of age or older, who have been committed by a judge of a district court in this state to the custody of the secretary under the provisions of K.S.A. 1982



Supp. 38-1663, may be admitted to a state youth center. (Authorized by K.S.A. 1982 Supp. 76-12a21; implementing K.S.A. 1982 Supp. 38-1663; effective May 1, 1976; amended May 1, 1983.)

**30-25-3.** (Authorized by K.S.A. 76-12a07; effective May 1, 1976; revoked May 1, 1983.)

**30-25-4.** (Authorized by K.S.A. 75-3335a, 76-12a07; effective May 1, 1976; revoked May 1, 1983.)

**30-25-5 to 30-25-7.** (Authorized by K.S.A. 76-12a07; effective May 1, 1976; revoked May 1, 1983.)

**30-25-8.** (Authorized by K.S.A. 75-3304, 76-12a07; effective May 1, 1976; revoked May 1, 1983.)

**30-25-9.** (Authorized by K.S.A. 76-12a07; effective May 1, 1976; revoked May 1, 1983.)

**Article 26.—STATE PSYCHIATRIC HOSPITALS; CATCHMENT AREAS; ASSISTANCE TO COUNTIES; PATIENT FUNDS; AND MEDICAL INFORMATION**

**30-26-1.** (Authorized by K.S.A. 75-3304, 76-12a07; implementing K.S.A. 59-2919; effective Jan. 1, 1967; amended Jan. 1, 1969; amended Jan. 1, 1972; amended, E-74-45, Sept. 30, 1974; amended May 1, 1975; amended May 1, 1983; revoked June 13, 1997.)

**30-26-1a. State hospital catchment areas.** (a) Persons residing in the following counties authorized by a participating mental health center to seek voluntary admission to a state psychiatric hospital or ordered to be involuntarily admitted by a district court acting pursuant to K.S.A. 59-2945, et seq., shall be admitted to or committed to the Larned state hospital: Barber, Barton, Cheyenne, Clark, Comanche, Decatur, Dickinson, Edwards, Ellis, Ellsworth, Finney, Ford, Gove, Graham, Grant, Gray, Greeley, Hamilton, Harper, Harvey, Haskell, Hodgeman, Kearny, Kingman, Kiowa, Lane, Lincoln, Logan, Marion, McPherson, Meade, Morton, Ness, Norton, Osborne, Ottawa, Pawnee, Phillips, Pratt, Rawlins, Reno, Rice, Rooks, Rush, Russell, Saline, Scott, Seward, Sheridan, Smith, Sherman, Stafford, Stanton, Stevens, Sumner, Thomas, Trego, Wallace, and Wichita.

(b) Persons residing in the following counties authorized by a participating mental health center

to seek voluntary admission to a state psychiatric hospital or ordered to be involuntarily admitted by a district court acting pursuant to K.S.A. 59-2945, et seq., shall be admitted to or committed to either the Osawatomie state hospital or the Rainbow mental health facility as designated by the participating mental health center authorizing the admission: Allen, Anderson, Atchison, Bourbon, Brown, Butler, Chase, Chautauqua, Cherokee, Clay, Cloud, Coffey, Cowley, Crawford, Doniphan, Douglas, Elk, Franklin, Geary, Greenwood, Jackson, Jefferson, Jewell, Johnson, Labette, Leavenworth, Linn, Lyon, Marshall, Miami, Mitchell, Montgomery, Morris, Nemaha, Neosho, Osage, Pottawatomie, Republic, Riley, Sedgwick, Shawnee, Wabaunsee, Washington, Wilson, Woodson, and Wyandotte.

(c) The state security hospital at Larned shall admit persons from all counties as ordered committed there, pursuant to K.S.A. 22-3302, 22-3303, 22-3428, 22-3428a, 22-3428b, 22-3429, or 22-3430.

(d)(1) Persons ordered committed to a state psychiatric hospital other than the state security hospital at Larned pursuant to K.S.A. 22-3302, 22-3303, 22-3428, 22-3428a, 22-3428b, 22-3429, 22-3430, or 38-1655 shall be admitted to the Larned state hospital if the person's county of residence is a county listed in subsection (a), or to the Osawatomie state hospital if the person's county of residence is a county listed in subsection (b).

(2) If the county of residence of the person ordered committed under paragraph (d)(1) cannot be reasonably determined, then that person shall be admitted to the Larned state hospital if the court committing that person is the court for a county listed in subsection (a), or to the Osawatomie state hospital if the court committing that person is the court for a county listed in subsection (b).

(e) Persons proposed to be committed by a court to a state psychiatric hospital pursuant to K.S.A. 22-3219, 38-1623, 38-1637, 38-1638, 38-1662, 59-29a05, 59-29a07 or any other provisions of law not provided for in this regulation, shall be admitted to the hospital designated by the secretary as the secretary may determine is a suitable place to which the person may be committed and at which space is available. (Authorized by K.S.A. 75-3304 and 76-12a07; implementing K.S.A. 22-3219, 22-3302, 22-3303, 22-3428, 22-3428a, 22-3428b, 22-3429, 22-3430, 38-1623, 38-1637, 38-

1638, 38-1655, 38-1662, 59-2968, 59-29a05, and 29a07; effective June 13, 1997.)

**30-26-2.** (Authorized by K.S.A. 1973 Supp. 75-3304, 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked June 13, 1997.)

**30-26-3. Payment for care and treatment.** Payment for the maintenance, care and treatment of persons admitted to a state hospital, state hospital and training center or the Kansas neurological institute, shall be made in accordance with K.S.A. 1973 Supp. 59-2006 and K.S.A. 59-2006a or any other Kansas statute particularly pertaining to said hospitals or institutions. At the same hospitals and institutions the maximum rate to be charged for the evaluation, care and treatment of outpatients (any patient not admitted as an inpatient such as day-treatment, night-treatment, part-time treatment patients or patients in study units, or other special non-inpatient programs) shall be set by the state director of mental health and retardation services at a reasonable rate not in excess of the actual costs for the particular services being given. The director may delegate to the superintendent the authority to grant allowances which will reduce the amount to be paid by the patient. In granting allowances the superintendent may take into consideration the therapeutic or treatment value of the charge to the patient, the ability of the individual being charged to pay, as well as the actual costs to the state for the services being performed. On past due outpatient accounts which have not been collected in full and the hospital or institution superintendent responsible for the setting of the charge determines that the unpaid balance is then unreasonable or uncollectible the same may be modified or cancelled but may not be increased from the original amount.

The state hospitals or institutions shall make collections for maintenance, care and treatment, but the final determination as to a compromise on any claim due shall be by the legal division of the state department of social and rehabilitation services. (Authorized by K.S.A. 1973 Supp. 75-3304, 76-12a07, K.S.A. 76-170; effective Jan. 1, 1967; amended Jan. 1, 1974.)

**30-26-4.** (Authorized by K.S.A. 1973 Supp. 75-3302c, 75-3304, 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked June 13, 1997.)

**30-26-5.** This rule and regulation shall be

revoked on and after December 29, 1995. (Authorized by K.S.A. 1973 Supp. 75-3304; effective Jan. 1, 1967; revoked Dec. 29, 1995.)

**30-26-6.** This rule and regulation shall be revoked on and after December 29, 1995. (Authorized by K.S.A. 1973 Supp. 75-3304; effective Jan. 1, 1967; revoked Dec. 29, 1995.)

**30-26-7.** (Authorized by K.S.A. 1973 Supp. 75-3304, 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked June 13, 1997.)

**30-26-8. Assistance to counties in establishing outpatient mental health treatment center or clinic.** The state director of mental health and retardation services shall have authority to assist communities in establishing outpatient mental health clinics or centers, following determination of need and the advisability of such facility, and the director may provide staff for the local clinics from the state mental hospitals to the extent he determines possible; such staffing to be on a temporary basis until the local clinic can secure permanent personnel. (Authorized by K.S.A. 1973 Supp. 75-3303a; effective Jan. 1, 1967; amended Jan. 1, 1974.)

**30-26-9. Establishment of patients' personal fund and patients' benefit fund.** There is hereby established at each institution under the state department of social and rehabilitation services a patients' personal fund and a patients' benefit fund. The patients' personal fund shall be established pursuant to K.S.A. 1973 Supp. 76-163, chapter 371, Laws of Kansas, 1973, and any directives of the state department of social and rehabilitation services. The patients' benefit fund shall be established pursuant to directives of the state department of social and rehabilitation services and shall receive and handle all nonappropriated funds including profits from canteen funds and nonofficial enterprises or activities received by an institution or the state department of social and rehabilitation services for the general use and benefit of all patients or residents of an institution. (Authorized by K.S.A. 1973 Supp. 75-3304, 76-163, 76-12a07; effective Jan. 1, 1967; amended Jan. 1, 1974.)

**30-26-10.** (Authorized by K.S.A. 75-3304, K.S.A. 1965 Supp. 76-2461; effective Jan. 1, 1967; revoked Jan. 1, 1974.)

**30-26-11. Definition of medical information.** The term medical information as used in

this regulation shall be considered to include but not limited to the following:

- (1) Discharge summaries.
- (2) Laboratory reports.
- (3) X-ray reports.
- (4) Diagnostic reports.
- (5) Physical, psychiatric or psychological reports or general medical reports.
- (6) Social histories. (Authorized by K.S.A. 1973 Supp. 76-12a10; effective Jan. 1, 1974.)

**30-26-12. Release without payment of fee.** Medical information may be provided without a payment of fee to the following: Patient, former patient, or his next of kin; any concerned state agency; state or national accreditation agency; scholarly investigator; federal agencies; physicians and hospitals; railroad or other retirement agencies; school, colleges and universities, community mental health/retardation facilities; alcoholism or other special care facilities; adult or children's care homes; prospective employers of former patients; courts and attorneys in judicial proceedings involving admission or discharge of a patient, or former patient. Nothing in this regulation shall be deemed to authorize release of information, but shall pertain solely to the question of release without payment of fee. Information can be released only upon standard release forms signed by the proper person or as authorized by K.S.A. 1972 Supp. 59-2931. (Authorized by K.S.A. 1973 Supp. 76-12a10; effective Jan. 1, 1974.)

**30-26-13. Release with payment of fee.** After receipt of the standard release form signed by the proper person authorized to consent to the release of medical information, this information may be released to the requesting party upon the payment of any fee required to be charged pursuant to K.A.R. 30-2-12. A statement of the charges shall be sent and the remittance received prior to the sending of medical information. The statement of charges shall be sent on a standard billing form approved by the director of mental health and retardation services. Receipts shall be deposited as outlined in chapter 369, Laws of Kansas, 1973. (Authorized by K.S.A. 75-5321, K.S.A. 1979 Supp. 45-204, 76-12a10; effective Jan. 1, 1974; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980.)

#### **Article 27.—OIL AND GAS LEASES ON INSTITUTIONAL PROPERTIES**

**30-27-1. Determination of land to be leased for oil, gas, or other mineral purposes.**

The secretary will determine which lands under his control may be leased for the production of oil, gas, or other materials without undue interference upon any state institution or any purpose or function of the secretary. (Authorized by K.S.A. 76-112, 76-112d; effective, E-74-26, May 1, 1974; effective May 1, 1975.)

**30-27-2. Bidders; notice; form of bids.** Legal notice to bidders for lease of designated oil, gas and other mineral lands shall be advertised for not less than five weeks in the Kansas register and shall be published in the county where the land is situated. The secretary shall accept the highest and optimum bid from a responsible bidder and shall reserve the right to reject any and all bids and to readvertise. Separate sealed bids for each tract of land shall be prepared on forms supplied by and filed with the secretary of social and rehabilitation services, and shall conform with the terms contained in the publication notice. A certified check or bank draft in the amount of the bid and payable to the secretary shall accompany all bids. The successful bidder may be required to pay publication costs before the awarded lease is executed. (Authorized by and implementing K.S.A. 76-112, 76-112e; effective, E-74-26, May 1, 1974; effective May 1, 1975; amended May 1, 1983.)

**30-27-3. Cash bonus, rental.** Bids for the leasing of oil and gas rights in lands designated by the secretary will be considered on the basis of a cash bonus, annual delay rental, and the amount of royalty to be paid shall not be less than 12½% of the gross proceeds at the prevailing market rate. Leases will be executed on a standard Kansas lease form. No lease shall be for a period to exceed five (5) years and so long thereafter as oil, gas, or other minerals, are being produced therefrom in paying quantities. (Authorized by K.S.A. 76-112; effective, E-74-26, May 1, 1974; effective May 1, 1975.)

**30-27-4. Indemnity bonds.** The secretary may require the filing of an indemnity bond, in an amount not to exceed \$50,000.00, by any successful bidder before the execution of an oil and gas lease with the bidder. The amount of the indemnity bond, if any, required for any oil and gas lease executed under these regulations shall be stated in the published notice for bids for that lease. The secretary may further require that the indemnity bond be in effect for the term of the lease and for

six months after the plugging of any well on the lease if this latter period exceeds the term of the lease. (Authorized by and implementing K.S.A. 76-112; effective, E-74-26, May 1, 1974; effective May 1, 1975; amended May 1, 1983.)

**30-27-5. Wells; operation and management.** Oil and gas lessees shall notify the secretary thirty (30) days prior to the commencement of each well drilling operation. All wells shall be spaced, located, operated, and maintained in accordance with all applicable state laws and regulations and shall be spaced, located, operated, and maintained at least 500 feet from any building on any state institution. The secretary may require the lessee of oil and gas rights to erect chain link fences of at least eight feet in height along their entire perimeter to fully enclose or encircle any drilling rig, pump, pipe, pool, pit, pile, housing or any other oil or gas drilling or production device or structure situated within 1,320 feet from any building, structure, or area normally used by institutional patients under the supervision or custody of any state institution or the secretary. The secretary may further prescribe reasonable procedures or safety devices to be followed or provided by the oil and gas lessees for the protection of residents, patients, or staff members of institutions from attractive nuisances or items inherently dangerous. The secretary shall notify the lessee of the need for correction of any dangerous devices or structures or the restoration of any land made dangerous by fill, excavation, or contamination from any operations of the lessee. The secretary may order the removal of any dangerous devices or structures or the restoration of any land made dangerous by fill, excavation, or contamination to its former state if the lessee fails to take any action within ninety (90) days after notification by the secretary to correct the dangerous device or structure or to restore land rendered dangerous to its former safe condition or if the lessee notifies the secretary that the lessee is unable to correct the dangerous devices, structures, or contaminations. The ordered removal or restoration operations shall, if possible, be performed by the lessee and the expenses of such operations shall be paid by the lessee. The costs of any above operations of removal or corrections that the secretary may be required to have performed due to refusal or inability of the lessee and the expenses of any uncorrected dangers or contaminations to land or property under the control of the secretary

may be charged against the indemnity bond, if any, filed by the lessee. (Authorized by K.S.A. 76-112, 76-112d; effective, E-74-26, May 1, 1974; effective May 1, 1975.)

#### Articles 28 to 30.—RESERVED

#### Article 31.—ALCOHOL AND DRUG ABUSE TREATMENT PROGRAMS

**30-31-1. Adoption by reference.** The document titled “standards for licensure/certification of alcohol and/or other drug abuse treatment programs,” dated November 1, 2006, by the Kansas department of social and rehabilitation services is hereby adopted by reference. (Authorized by K.S.A. 39-708c, 65-4016, and 65-4607; implementing K.S.A. 65-4011, 65-4013, 65-4014, 65-4015, 65-4016, 65-4019, 65-4024, 65-4603, and 65-4605; effective May 1, 1976; amended May 1, 1978; amended Jan. 5, 2007.)

**30-31-2.** (Authorized by and implementing K.S.A. 39-708c, 65-4011, 65-4016, 65-4607; effective May 1, 1976; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1988; revoked Jan. 5, 2007.)

**30-31-3.** (Authorized by K.S.A. 39-708c, 65-4016, 65-4607; implementing K.S.A. 65-4011, 65-4012, 65-4013, as amended by L. 1987, Ch. 243, Sec. 1, 65-4014, as amended by L. 1987, Ch. 243, Sec. 2, 65-4601, 65-4603, as amended by L. 1987, Ch. 251, Sec. 1, 65-4605, as amended by L. 1987, Ch. 251, Sec. 3; effective May 1, 1976; amended May 1, 1978; amended, T-88-37, Sept. 17, 1987; amended May 1, 1988; revoked Jan. 5, 2007.)

**30-31-4.** (Authorized by K.S.A. 39-708c, 65-4016, 65-4607; implementing K.S.A. 65-4013, as amended by L. 1987, Ch. 243, Sec. 1, 65-4014, as amended by L. 1987, Ch. 243, Sec. 2, 65-4603, as amended by L. 1987, Ch. 251, Sec. 1, 65-4605, as amended by L. 1987, Ch. 251, Sec. 3; effective May 1, 1976; amended May 1, 1978; amended, T-88-37, Sept. 17, 1987; amended May 1, 1988; revoked Jan. 5, 2007.)

**30-31-5.** (Authorized by K.S.A. 1977 Supp. 39-708c, 65-4016; effective May 1, 1976; revoked May 1, 1978.)

**30-31-6.** (Authorized by K.S.A. 1977 Supp.



39-708c, 65-4016; effective May 1, 1976; amended May 1, 1978; revoked Jan. 5, 2007.)

**30-31-7.** (Authorized by and implementing K.S.A. 1992 Supp. 39-708c, K.S.A. 65-4016, 65-6601 through 65-6606, inclusive, and 74-7507; effective May 1, 1976; amended May 1, 1978; amended, T-30-6-15-93, June 15, 1993; amended July 26, 1993; revoked Jan. 5, 2007.)

**30-31-8 and 30-31-9.** (Authorized by K.S.A. 1977 Supp. 39-708c, 65-4016; effective May 1, 1976; revoked May 1, 1978.)

**30-31-10.** (Authorized by K.S.A. 1977 Supp. 39-708c, 65-4016; effective May 1, 1976; amended May 1, 1978; revoked Jan. 5, 2007.)

**30-31-11.** (Authorized by K.S.A. 1977 Supp. 39-708c, 65-4016; effective May 1, 1976; amended May 1, 1978; revoked Jan. 5, 2007.)

**30-31-11. Change of terminology.** The department may change the name of the different classes of treatment programs when necessary to avoid confusion in terminology, and the department may further define and identify the specific acts and services which shall fall within the respective categories of programs. (Authorized by K.S.A. 1977 Supp. 39-708c, 65-4016; effective May 1, 1976; amended May 1, 1978.)

**30-31-12.** (Authorized by K.S.A. 1977 Supp. 39-708c, 65-4016; effective May 1, 1978; revoked Jan. 5, 2007.)

**30-31-13.** (Authorized by and implementing K.S.A. 8-1008; effective May 1, 1983; revoked, T-84-11, July 1, 1983; revoked May 1, 1984.)

#### **Articles 32 to 39.—RESERVED**

#### **Article 40.—DRUG TREATMENT FACILITIES OF THE KANSAS DRUG ABUSE UNIT**

**30-40-1 to 30-40-9.** (Authorized by K.S.A. 75-5375; effective, E-77-44, Sept. 23, 1976; effective Feb. 15, 1977; revoked May 1, 1978.)

#### **Article 41.—LICENSING OF COMMUNITY BASED AGENCIES PROVIDING SERVICES TO ADULTS WITH MENTAL RETARDATION OR OTHER DEVELOPMENTAL DISABILITIES**

**30-41-1.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and im-

plementing K.S.A. 75-3307b; effective May 1, 1979; amended May 1, 1980; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended July 1, 1991; amended Feb. 6, 1995; revoked July 1, 1996.)

**30-41-2.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1979; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1984; amended May 1, 1985; amended May 1, 1987; revoked July 1, 1996.)

**30-41-3.** This regulation shall be revoked on and after July 1, 1996. (Authorized by K.S.A. 75-3307b; effective May 1, 1979; revoked July 1, 1996.)

**30-41-4.** This regulation shall be revoked on and after July 1, 1996. (Authorized by K.S.A. 75-3307b; effective May 1, 1979; amended May 1, 1985; revoked July 1, 1996.)

**30-41-5.** This regulation shall be revoked on and after July 1, 1996. (Authorized by K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1979; amended May 1, 1980; amended May 1, 1985; amended May 1, 1987; revoked July 1, 1996.)

**30-41-6.** (Authorized by and implementing K.S.A. 1980 Supp. 75-3307b; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-82-19, Oct. 21, 1981; revoked May 1, 1982.)

**30-41-6a.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1983 Supp. 75-3307b; effective May 1, 1982; amended May 1, 1984; revoked July 1, 1996.)

**30-41-6b.** This regulation shall be revoked on and after January 1, 1997. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b; effective May 1, 1982; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; revoked Jan. 1, 1997.)

**30-41-6c.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective

May 1, 1982; amended May 1, 1987; revoked July 1, 1996.)

**30-41-6d.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; revoked July 1, 1996.)

**30-41-6e.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; revoked July 1, 1996.)

**30-41-6f.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b; effective May 1, 1984; amended May 1, 1985; revoked July 1, 1996.)

**30-41-6g.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b; effective May 1, 1984; amended May 1, 1985; revoked July 1, 1996.)

**30-41-6h.** This regulation shall be revoked on and after July 1, 1996. (Authorized by K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; revoked July 1, 1996.)

**30-41-7.** (Authorized by and implementing K.S.A. 1980 Supp. 75-3307b; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-82-19, Oct. 21, 1981; revoked May 1, 1982.)

**30-41-7a.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1990 Supp. 75-3307b; effective May 1, 1982; amended July 1, 1991; revoked July 1, 1996.)

**30-41-7b.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; revoked July 1, 1996.)

**30-41-7c.** This regulation shall be revoked

on and after July 1, 1996. (Authorized by and implementing K.S.A. 1981 Supp. 75-3307b; effective May 1, 1982; revoked July 1, 1996.)

**30-41-7d.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1982; amended May 1, 1987; revoked July 1, 1996.)

**30-41-7e.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1983 Supp. 75-3307b; effective May 1, 1982; amended May 1, 1984; revoked July 1, 1996.)

**30-41-7f.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1983 Supp. 75-3307b; effective May 1, 1982; amended May 1, 1984; revoked July 1, 1996.)

**30-41-7g.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1982; amended May 1, 1984; amended May 1, 1987; revoked July 1, 1996.)

**30-41-7h.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b; effective May 1, 1982; amended May 1, 1986; revoked July 1, 1996.)

**30-41-7i.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1990 Supp. 75-3307b; effective July 1, 1991; revoked July 1, 1996.)

**30-41-8.** This regulation shall be revoked on and after July 1, 1996. (Authorized by K.S.A. 75-3307b; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked July 1, 1996.)

**30-41-9. Reserved.**

**30-41-10 to 30-41-19.** (Authorized by K.S.A. 75-3307b; effective May 1, 1985; revoked June 28, 1996.)

**30-41-20.** This regulation shall be revoked on and after July 1, 1996. (Authorized by and implementing K.S.A. 1990 Supp. 75-3307b; effective July 1, 1991; revoked July 1, 1996.)

**Article 42.—LICENSING OF NON-MEDICAL RESIDENT CARE FACILITIES**

**30-42-1.** (Authorized by K.S.A. 1978 Supp. 39-708c; effective May 1, 1979; revoked May 1, 1984.)

**30-42-2.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1979; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; revoked May 1, 1984.)

**30-42-3 and 30-42-4.** (Authorized by K.S.A. 1978 Supp. 39-708c; effective May 1, 1979; revoked May 1, 1984.)

**30-42-5.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1979; amended May 1, 1980; amended, E-82-19, Oct. 21, 1981; revoked May 1, 1982.)

**30-42-5a to 30-42-5g.** (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; revoked May 1, 1984.)

**30-42-6. Definitions.** (a) “Applicant” means any facility which applies for a license issued by the department to provide residential care.

(b) “Department” means the Kansas state department of social and rehabilitation services.

(c) “Facility” means any private person, group, association or corporation, or any community or local government department undertaking to provide residential care within the meaning of these regulations.

(d) “Handicapped” means a physical, mental, or emotional impairment which limits one or more major life activities.

(e) “Mental or emotional abuse” means any method of inflicting or causing mental injury or causing deterioration of the individual. Mental or emotional abuse includes failure to maintain reasonable care or treatment to such an extent that the individual’s emotional well-being is in danger.

(f) “Secretary” means the secretary of the department of social and rehabilitation services.

(g) “Staff” means employees of the facility who spend a majority of their work time in the supervision of residents. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-7. Licensing procedures.** (a) Each

facility shall apply for a license on application forms provided by the department.

(b) Each application for renewal of a license shall be submitted by the licensed facility to the department at least 60 days before expiration of the license. This provision may be waived by the department upon a showing of good cause by the facility.

(c) At the discretion of the department, a provisional license may be issued to any facility that is substantially in compliance with the licensing regulations, if the facility presents evidence that any deficiency is temporary and if efforts to correct the deficiency are agreed to or are in progress. Each provisional license shall become a regular license at the end of a period of 180 days if the department agrees, in writing, that the previously noted deficiencies have been corrected. If the deficiencies have not been corrected, the provisional license shall automatically lapse at the end of the 180-day period.

(d) Each license issued shall specify and shall be valid only for the facility and the operator named on the license. A new application shall be required for each change of operator. A facility which changes operators may continue to provide the same care which it was licensed to provide under its last prior operator for the period of time that is required for the facility to pursue all administrative avenues available under these regulations for obtaining licensure under the facility’s new operator.

(e) The license shall be issued for a specified period of time not to exceed one year.

(f) The department, upon request, may waive any specific licensing standard for good cause if such waiver does not affect the health, safety or welfare of a facility’s residents. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-8. Capacity.** Each license shall specify the maximum number of residents who may be served at any one time in the facility. That maximum number shall not be less than five nor more than 40. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-9. Suspension or revocation of license.** (a) The license of any facility shall be sus-

pending or revoked according to the provisions of this subsection (a) whenever:

(1) The department finds that the facility has failed to comply with the provisions of K.A.R. 30-2-15 or of any licensing regulations set forth in this article and there is reason to believe that the facility will be in further non-compliance; or

(2) the department finds that the facility is in continuing non-compliance with K.A.R. 30-2-15 or of any licensing regulations set forth in this article.

(b) Procedures for the suspension or revocation of a license.

(1) Subject to the provisions of paragraph (2) of this subsection, when the department finds that a licensed facility is not in compliance with the provisions of any licensing regulations set forth in this article, the department shall informally advise the facility's operator or chief officer in person or by telephone of a finding of non-compliance. This informal communication shall be confirmed in writing within five working days of the informal advice. The written confirmation of the advice shall:

(A) Specify in detail the noted items of non-compliance;

(B) inform the facility of the action required to correct the non-compliance;

(C) inform the facility that failure to provide evidence that the non-compliance has been corrected will result in suspension or revocation of the facility's license;

(D) inform the facility of the time period within which the item of non-compliance can be corrected without temporary or permanent loss of license. This time period shall not be less than 45 days from the date of written confirmation; and

(E) inform the facility of the name and address of the person within the department to whom evidence must be provided demonstrating that the item of non-compliance has been corrected.

(2) The department shall immediately suspend the license of any facility whose non-compliance with these regulations is of a nature so serious that such non-compliance will constitute an immediate threat to the health, safety or welfare of the facility's residents. The department shall immediately initiate an action to revoke such a license according to these regulations.

(3) Whenever a facility has failed to satisfy the department that an item of non-compliance has been corrected as provided in paragraph (1) of this subsection, or whenever the department has

suspended a facility's license under paragraph (2) of this subsection, action shall be commenced to revoke the facility's license. Prior to revocation of a facility's license, the department shall send to the facility a written notification of the proposed revocation and the reasons therefor. The notice shall state whether the facility's license has been suspended pending further proceedings. If the decision is to revoke the facility's license as herein provided, the department shall issue a written order of revocation setting forth the effective date of such revocation and the basic underlying facts supporting the order. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-10. Prerequisites for license.** (a)

Any applicant for licensure shall be at least 18 years of age at the time of application.

(b) Each facility for eight or more persons shall be approved by the Kansas department of health and environment as meeting the standards for a lodging establishment under the food service and lodging act.

(c) Each facility shall meet the legal requirement of the community for zoning, fire protection, water supply and sewage disposal.

(d) Each facility shall obtain and retain on file a fire life safety code report issued within the previous 12 months by the state fire marshal, or persons designated in K.S.A. 31-137 and amendments thereto. Deficiencies noted on the report shall be the subject of an acceptable plan of correction submitted to the state fire marshal within the time-frame established by the state fire marshal. The facility shall adhere to the plan of correction as well as the date, if any, by which the correction is to be made.

(e) Each facility shall provide and maintain fire protection equipment. This equipment shall be approved as adequate by the state fire marshal.

(f) Each facility shall employ at least one staff person certified in the administration of first-aid. All other staff shall receive training in the administration of first-aid within 30 days of employment and every two years thereafter. The date of that training shall be recorded for each staff person and retained on file.

(g) Each facility shall provide adequate care of residents and shall not exceed a maximum ratio of 20 residents to one staff person.

(h) Each facility shall allow residents the right



of privacy and the right to see relatives, friends and participate in regular community activities.

(i) Corporal punishments restraints or punitive measures shall not be used by any facility.

(j) Each facility shall develop a current, written grievance procedure for residents.

(k) Each facility shall see that arrangements are made for emergency and regular medical care for residents.

(l) Each facility shall allow the secretary and authorized representatives of the secretary access to the home, grounds, residents and to records related to residents.

(m) Facility personnel shall not accept permanent guardianship or conservatorship of residents. However, guardianship or conservatorship of blood relatives shall be permitted.

(n) Each facility shall maintain official policies and make them available for review by the department, staff, residents, and guardians and relatives of residents. The official policies of each facility shall contain statements regarding the provisions of subsections (g), (h), (i), (j) and (k) set forth above. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-11. Admission and discharge policies.** (a) Each facility shall have on file and shall provide to the department an admissions policy. At a minimum, the admissions policy shall indicate the types of residents the facility will accept indicating:

- (1) Age range;
- (2) sex;
- (3) type of disability; and
- (4) the types of residents the facility will not accept.

(b) The facility shall make an inventory of each resident's major personal items within 24 hours of the resident's admission to the facility. Documentation of the inventory shall be retained on file.

(c) Prior to or within 24 hours of admission, the facility shall obtain and retain on file a document signed by the resident and guardian, if any, verifying that they have received in writing the phone number which they may call at any time to complain about exploitation, neglect, or abuse, including mental or emotional abuse.

(d) The facility shall be responsible for encouraging residents to seek and utilize available services when needed.

(e) The facility shall agree to refer a resident to other appropriate residential facilities as soon as it determines that the needs of a resident can no longer be met by the facility.

(f) The resident shall not be involuntarily transferred or discharged from the facility except:

(1) For medical or behavioral reasons which render the facility an inappropriate placement;

(2) for the welfare of the resident or others; or

(3) for non-payment of the rates and charges imposed by the facility.

(g) Except in emergencies, the resident and legal guardian, if any, shall be given written notice at least seven days in advance of a transfer or discharge of the resident. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-12. Disaster policies.** The facility shall, in consultation with the fire inspector or other appropriate resources, develop a written disaster plan to provide for the care and safety of residents and employees in emergencies and in occurrences of serious illness or injury. The residents and employees shall be informed of the disaster plan and the plan, including an exit diagram, shall be posted. Evacuation drills shall be conducted each quarter and the date and the length of time for evacuation shall be recorded. A telephone shall be located on the premises and readily available. Emergency numbers shall be posted by each phone. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-13. Health policies.** (a) The facility may assist with the taking of medication when the medication is in a labeled bottle dispensed by a pharmacist which clearly shows a physician's orders and when the resident requires assistance because of tremor, visual impairment, or other physical or mental handicapping conditions. The facility may assist the residents with such physical activities as eating, bathing, dressing, help with brace or walker, and transferring from wheelchairs when such assistance is needed on a temporary or intermittent basis.

(b) Each facility shall provide a sanitary environment and shall follow proper techniques of asepsis and isolation for residents with infections and contagious diseases.

(c) All outdated or discontinued medication

shall be discarded in the presence of the supervisor.

(d) Each employee infected with a disease in a communicable form or having communicable skin lesions shall be restricted from work until the disease is no longer communicable. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-14. Financial policies.** The personal money of each resident shall be kept in the resident's individual account. The individual account shall be separate from the funds of the facility, owner, operator, employees, and other residents. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-15. Adult residential sleeping quarters.** (a) Sleeping quarters shall have a minimum of 70 square feet per person of free floor space in single rooms and an average of not less than 55 square feet per person in rooms accommodating more than one person.

(b) Rooms used as sleeping quarters shall have windows that are operable without a tool. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

**30-42-16. Environmental standards.** (a) Each facility shall comply with the standards set forth below. The department may consider, but need not accept, written statements of compliance with environmental requirements from other authorized licensing agencies or groups.

(b) The building shall be clean, in good state of repair, and free from accumulated dirt or trash and vermin infestation.

(c) Aisles, hallways, stairways, and main routes of travel shall be maintained free of obstacles and stored materials.

(d) Furniture shall be clean and in good state of repair.

(e) Rooms shall be well-ventilated, adequately lighted, and appropriately heated or cooled.

(f) Each resident shall have a separate bed with a level, flat mattress in good condition, and sufficient and clean bedding.

(g) Bathroom fixtures shall be accessible, clean, and in good state of repair.

(h) Kitchenware and tableware shall be clean and in good condition.

(i) Meals and snacks, when provided, shall be appropriate to the nutritional needs of the residents. Menus shall be posted and shall follow the basic food group requirements.

(j) The outside area shall be free of physical hazards and be free of accumulated garbage and trash. (Authorized by and implementing K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective, T-87-20, Sept. 1, 1986; effective May 1, 1987.)

#### Article 43.—CORPORATE GUARDIANS

**30-43-1. Certification of corporate guardians.** (a) Each corporation requesting to be certified as suitable to perform the duties of a guardian shall make application on forms prescribed by the secretary. Each corporation, along with its application, shall furnish the agency with a copy of its articles of incorporation, an organizational chart, including the names of the board of directors, a current financial statement, and a detailed plan of operation concerning its functions as a corporate guardian. The corporation shall update the information provided on the application and attachments, as necessary.

(b) To be eligible for certification, each corporation shall:

- (1) Provide proof of corporate stability;
- (2) provide proof of financial solvency;
- (3) have access to qualified professionals to provide consultation concerning the needs of the wards for whom the corporation is acting as guardian;

- (4) have access to an attorney to provide necessary legal services in relationship to its guardian responsibilities;

- (5) maintain liability insurance coverage of at least \$25,000.00 per occurrence for the protection of the wards from corporate negligence;

- (6) provide orientation and in-service training, as approved by the agency, to persons working with wards and their supervisors. No person may serve as a supervisor or be directly responsible for a ward unless that person has attended the required orientation or in-service training sessions, as appropriate;

- (7) assign a specific individual to be directly responsible for each ward. No person shall be directly responsible for more than 15 wards;

- (8) assign a supervisor to each person who is

directly responsible for a ward. No supervisor shall have more than 10 supervisees;

(9) not assign a person to be a supervisor or to work with wards if that person has ever been:

(A) Convicted of a felony or crime against persons;

(B) removed as a guardian or conservator by the court for cause; or

(C) relieved of responsibilities in the guardianship program by a corporation for cause;

(10) ensure that the person assigned the direct responsibility for a ward lives within 50 miles of the ward, has an active involvement with the ward and makes contact with the ward, as necessary, encourages appropriate interaction of immediate family members, relatives, and friends with the ward, and effectively carries out the corporation's guardianship responsibility to the ward. The person who is assigned responsibility for a ward shall contact the ward at least once each week and shall meet in person with the ward at least once each month. If a ward's mental status is diminished to the extent that the ward cannot communicate with the person assigned to the ward, the weekly contact shall be with a person who has day to day contact with the ward or who supervises such activities;

(11) designate back-up persons for each person assigned to a ward and maintain a 24 hour telephone system, at no cost to the ward, to ensure coverage in an emergency;

(12) ensure that a ward is not used in a fund raising or publicity campaign without the approval of the agency;

(13) have a written grievance procedure for wards;

(14) assign a specific staff person to act on behalf of the corporation to carry out the corporation's guardianship responsibility for each ward for whom the corporation is acting as guardian;

(15) maintain a file and case log for each ward;

(16) furnish reports to the agency, as requested;

(17) report serious injuries of wards to the agency within 72 hours of their occurrence;

(18) notify the agency if a supervisor or person working with a ward is:

(A) Convicted of a felony or crime against persons;

(B) removed as a guardian or conservator by the court for cause; or

(C) relieved of responsibilities in the guardianship program by a corporation for cause; and

(19) allow the agency to have access to wards and their records.

(c) Hearings to revoke certification shall be conducted pursuant to K.A.R. 30-7-26, et seq. (Authorized by and implementing L. 1983, Ch. 191; effective, T-84-36, Dec. 21, 1983; effective May 1, 1984.)

#### Article 44.—SUPPORT ENFORCEMENT

**30-44-1.** (Authorized by K.S.A. 1983 Supp. 39-756; effective May 1, 1985; revoked, T-86-26, Aug. 19, 1985; revoked May 1, 1986.)

**30-44-2. Standardized cost recovery fee.** (a) As used in this regulation, the following definitions shall apply:

(1) "Applicant or recipient" means a person who has applied for or is receiving support enforcement services from the department of social and rehabilitation services pursuant to Part D of Title IV of the federal social security act, 42 U.S.C. § 651 *et seq.*, as amended.

(2) "IV-D case" means a case in which the department of social and rehabilitation services is providing support enforcement services pursuant to Part D of Title IV of the federal social security act, 42 U.S.C. § 651 *et seq.*, as amended.

(3) As used in this rule and regulation, the following definitions shall apply:

(A) "Non-PA case" means a case in which the applicant or recipient or the child, as appropriate, has not received and is not currently receiving public assistance from the state of Kansas, including the following:

(1) Aid to families with dependent children (AFDC) or temporary assistance to needy families (TANF), regardless of how designated;

(2) medical services;

(3) care due to placement under chapter 38 of the Kansas statutes annotated and amendments thereto; or

(4) care in a state institution as defined in K.S.A. 59-2006b and amendments thereto.

(B) "Non-PA case" shall also mean, in any IV-D case in which the applicant or recipient or the child previously received but is not currently receiving public assistance from the state of Kansas, that portion of the case not subject to any assignment of support rights for reimbursement of public assistance.

(C) In an interstate IV-D case referred to Kansas by another state, unless the other state clearly designates otherwise, "Non-PA case" shall mean

a case, or that portion of a case, designated as IV-D non-AFDC or IV-D non-TANF.

(D) "Non-PA" case shall not include any IV-D case referred to Kansas from a foreign country.

(b) A cost recovery fee shall be collected in all Non-PA cases. The fee shall be retained from support collections made on behalf of the applicant or recipient. If any fee remains unpaid and the applicant or recipient will receive no further support collections in the Non-PA case, the fee shall be remitted by the applicant or recipient upon demand.

(c) Except as otherwise provided in subsection (d), the fee shall be in an amount equal to the basic rate times the amount of support collections distributed to the applicant or recipient. The date of collection shall determine the applicable basic rate. The basic rate shall be two percent through December 31, 1999. Beginning January 1, 2000, the basic rate shall be four percent.

(d)(1) As needed, but no more frequently than annually, Kansas counties shall be identified in which the average fee income per case will exceed the average actual cost of required activities. The counties shall be identified in consultation with the judicial administrator. The average fee income per case shall be estimated by first multiplying the fee rate established in subsection (c) of this regulation times the estimated average of current monthly support obligations for the county and then multiplying the result by 12. The average cost per case of required activities shall be based upon the estimated actual cost of providing services during the next 12 months using state employees. Costs for activities required less frequently than annually shall be prorated.

(2) A special fee rate shall be established for each county identified under paragraph (d)(1) of this regulation. The special fee rate shall be in an amount likely to produce average fee income per case less than, but as close as possible to, the average cost per case of required activities. If there is a district court trustee for the county, the special fee rate shall be the same as the rate charged by the district court trustee in non-IV-D cases pursuant to K.S.A. 23-497 and amendments thereto, if the trustee's fee rate does not exceed the fee rate established in subsection (c) of this regulation.

(3) Any county that has had a special fee rate in effect may be reevaluated to determine whether the special fee rate is still needed and, if

so, the appropriate fee rate. The reevaluation shall not occur more frequently than annually.

(4) A list shall be maintained of the special fee rates currently in effect and the counties to which the special fee rates apply. (Authorized by and implementing K.S.A. 39-756; effective Feb. 6, 1995; amended Jan. 3, 2000.)

**30-44-3. Birthing hospital.** (a) "Birthing hospital" means a hospital that has a licensed obstetric care unit or is licensed to provide obstetric services, or a licensed facility outside a hospital that provides maternity services and is associated with a hospital.

(b) This regulation shall become effective 45 days following publication in the Kansas Register. (Authorized by and implementing L. 1994, Chapter 292, Section 1; effective Feb. 6, 1995.)

**30-44-4. Disclosure to credit reporting agencies.** (a) Except as provided in subsection (b) or (c), the following information shall be made available periodically to consumer credit agencies:

(1) the name of any parent who owes overdue support and is at least two months delinquent in the payment of such support; and

(2) the amount of such delinquency. Additional information about the parent or the debt may be provided to the consumer reporting agency. Except as provided in subsection (b) or (c), the name of any other parent who owes support, together with information about the debt, may be made available to consumer reporting agencies.

(b) Debt information regarding particular cases shall not be made available pursuant to this regulation to:

(1) any consumer reporting agency which the secretary or the secretary's designee determines does not have sufficient capability to make accurate use of such information in a systematic and timely manner; or

(2) an entity which has not furnished evidence satisfactory to the secretary or the secretary's designee that the entity is a consumer reporting agency.

(c) Notwithstanding any other provision of this regulation, it may be determined that providing debt information to a consumer reporting agency in any particular case is not appropriate because of the circumstances of the case.

(d) No fee will be charged to a consumer reporting agency requesting support arrearage information under this regulation.

(e) The effective date of this regulation shall



be September 1, 1995. (Authorized by and implementing K.S.A. 23-4,145; effective Sept. 1, 1995.)

**30-44-5. Scope of services; judgment interest.** (a) Except as otherwise provided in subsection (b), the scope of child support enforcement services related to judgment interest shall be limited to enforcement of a lump sum previously determined by a tribunal of competent jurisdiction, if the judgment interest debt can be enforced in the same manner as that for a debt for child support.

(b) If the director of child support enforcement services determines that conducting or participating in a pilot project is in the best interests of the child support enforcement program, additional services related to judgment interest may be authorized by the director in cases selected for the pilot project.

(c) This regulation shall be effective on and after July 1, 2003. (Authorized by and implementing K.S.A. 39-753; effective July 1, 2003.)

#### Article 45.—YOUTH SERVICES

**30-45-1. Adoption—genetic and medical history of parents.** Each person, other than a stepparent, filing a petition to adopt a minor, shall file with the petition a statement relative to:

(a) The history of significant illnesses or hospitalizations of the genetic parents; and

(b) the indication of any conditions, ailments, maladies, handicaps, genetically transmitted or communicable diseases which are known to exist within the parent or their family background which might affect the health or development of the child. (Authorized by and implementing K.S.A. 1985 Supp. 59-2278a; effective, T-86-30, Sept. 24, 1985; effective May 1, 1986.)

**30-45-2. Adoption—medical history of child.** The medical history of the child filed with the adoption petition shall include the following information and facts about the child's birth and health history: (a) The date, time, place of the birth of the child and the name of the attending physician;

(b) whether the child was full-term or premature;

(c) the child's weight and length at birth;

(d) type of delivery;

(e) whether there were any complications during pregnancy or at birth;

(f) a history of any childhood diseases;

(g) a history of immunizations and tests;

(h) a history of any significant illnesses or hospitalizations since birth;

(i) a history of any chronic health problems, diseases or disabilities affecting the child;

(j) the date of birth and sex of any of the child's siblings, if known; and

(k) a record of the child's developmental milestones. (Authorized by and implementing K.S.A. 1985 Supp. 59-2278a; effective, T-86-30, Sept. 24, 1985; effective May 1, 1986.)

**30-45-3. Adoption—social history.** The following information shall be filed with the petition as the social history of the biological parents on forms prescribed by the secretary:

(a) Each parent's religious background;

(b) each parent's educational background;

(c) each parent's ethnic background;

(d) each parent's tribal membership, if applicable; and

(e) each parent's employment history. (Authorized by and implementing K.S.A. 1985 Supp. 59-2278a; effective, T-86-30, Sept. 24, 1985; effective May 1, 1986.)

**30-45-4. Adoption—procedures for updating histories.** (a) The person filing the petition to adopt shall provide written notification to the biological parent of the process for notifying social and rehabilitation services of any new genetic or medical information which might affect the child.

(b) The person filing the petition to adopt shall advise the adoptive family in writing that genetic and medical information is permanently filed with social and rehabilitation services. (Authorized by and implementing K.S.A. 1985 Supp. 59-2278a; effective, T-86-30, Sept. 24, 1985; effective May 1, 1986.)

#### **30-45-5 to 30-45-9. Reserved.**

**30-45-10. Definitions.** (a) "Medical neglect" includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition.

(b) "Withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by failing to provide treatment, which in the treating physician's reasonable medical judgment, is most likely to ameliorate or correct all life-threatening conditions, except when the treatment would be futile in terms of survival of the infant and the treatment

itself under such circumstances would be inhumane. In all circumstances "withholding of medically indicated treatment" shall always include the failure to provide appropriate nutrition, hydration or medication.

(c) "Reasonable medical judgment" means a medical judgment made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

(d) "Infant" means an infant less than one year of age. The reference to less than one year of age shall not be construed to imply that treatment should be changed or discontinued when an infant reaches one year of age. The standards set forth in subsection (b) of this regulation should be consulted thoroughly in the evaluation of any issue of medical neglect involving an infant older than one year of age who has been continuously hospitalized since birth, whose birth was extremely premature, or who has a long-term disability.

(e) "Designated hospital liaison" means the individual designated by the hospital administrator as the person to be contacted by agency personnel upon a report of medically indicated treatment being withheld from a disabled infant. Names of liaisons shall be furnished to the agency annually by each hospital.

(f) "Hospital medical ethics review committee" means the group established by the hospital to review medical treatment and make recommendations to the appropriate medical personnel involved in the case. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22, 1986; effective May 1, 1987.)

**30-45-11. Reports of medically neglected infants.** (a) Reports of medical neglect of a disabled infant shall be made to the local social and rehabilitation services office. Receipt of the report and subsequent initiation of an investigation will follow the emergency procedures established under the Kansas code for care of children. Upon receiving notification of withholding of medically indicated treatment from a disabled infant, an agency social worker shall:

(1) Contact the designated hospital liaison at the facility where the infant is located;

(2) contact the hospital medical ethics review committee at the facility housing the infant to obtain the committee's findings or the Kansas perinatal medical council if no hospital medical ethics review committee exists; and

(3) include as a part of the investigative report, information from and reports to the designated hospital liaison and the hospital medical ethics review committee or the Kansas perinatal medical council if no hospital medical ethics review committee exists.

(b) Subsequent to the initial investigation of a report of medical neglect of a disabled infant, the agency personnel shall follow the procedures established under the Kansas code for care of children and all due process rights contained therein shall apply. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22, 1986; effective May 1, 1987.)

**30-45-12. Responsible reporters.** (a) Physicians, nurses, hospital administrators and others listed in K.S.A. 1985 Supp. 38-1522 shall be required to report cases of medical neglect of disabled infants.

(b) Reports to social and rehabilitation services of medical neglect of disabled infants can be initiated by any concerned citizen. The reporter will remain anonymous unless the reporter agrees to the use of the reporter's identity by the agency. The reporter is not liable to prosecution for reports made in good faith pursuant to K.S.A. 1985 Supp. 38-1525 and 38-1526. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22, 1986; effective May 1, 1987.)

**30-45-13. Records.** Records of medical neglect cases involving disabled infants shall be handled according to established agency procedures. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective May 1, 1987.)

**30-45-14. Public information.** The medical community shall be annually informed of the need to report cases of alleged medical neglect of disabled infants pursuant to these regulations. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22, 1986; effective May 1, 1987.)

## **Article 46.—CHILD ABUSE AND NEGLECT**

**30-46-1.** (Authorized by and implementing K.S.A. 39-708c, 65-516, as amended by L. 1987,

Ch. 233, Sec. 1; effective, T-88-14, July 1, 1987; effective May 1, 1988; revoked Jan. 2, 1989.)

**30-46-2.** (Authorized by and implementing K.S.A. 39-708c, 65-516, as amended by L. 1987, Ch. 233, Sec. 1; effective, T-88-14, July 1, 1987; effective May 1, 1988; revoked Jan. 2, 1989.)

**30-46-3.** (Authorized by and implementing K.S.A. 39-708c, 65-516, as amended by L. 1987, Ch. 233, Sec. 1; effective, T-88-14, July 1, 1987; effective May 1, 1988; revoked Jan. 2, 1989.)

**30-46-4.** (Authorized by and implementing K.S.A. 39-708c, 65-516, as amended by L. 1987, Ch. 233, Sec. 1; effective, T-88-14, July 1, 1987; effective May 1, 1988; revoked Jan. 2, 1989.)

**30-46-5.** (Authorized by and implementing K.S.A. 39-708c, 65-516, as amended by L. 1987, Ch. 233, Sec. 1; effective, T-88-14, July 1, 1987; effective May 1, 1988; revoked Jan. 2, 1989.)

**30-46-6.** (Authorized by and implementing K.S.A. 39-708c, 65-516, as amended by L. 1987, Ch. 233, Sec. 1; effective, T-88-14, July 1, 1987; effective May 1, 1988; revoked Jan. 2, 1989.)

**30-46-7 to 30-46-9. Reserved.**

**30-46-10. Definitions.** Pursuant to K.S.A. 38-1523 and amendments thereto, the following definitions shall apply. (a) "Abuse" means any act or failure to act that results in any of the following to a child under the age of 18 who resides in Kansas or is found in Kansas, regardless of where the act or failure to act occurred:

- (1) Death;
  - (2) physical injury or deterioration or the imminent risk of serious injury;
  - (3) mental or emotional injury or deterioration;
- or
- (4) sexual abuse.

This term shall include any act or failure to act that occurred in Kansas, regardless of where the child is found or resides.

(b) "Alleged perpetrator" means the person identified in the initial report or during the investigation as the person suspected of perpetrating an act of abuse or neglect.

(c) "Department" means the Kansas department of social and rehabilitation services.

(d) "Investigation" means the gathering and assessing of information to determine if a child has been abused or neglected.

(e) "Mental or emotional abuse" means the in-

fliction of mental or emotional injury on a child or the causation of a child's deterioration. This term may include the following:

(1) Any act or omission that impairs a child's social, emotional, or intellectual functioning;

(2) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;

(3) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;

(4) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior;

(5) maltreating or exploiting a child to the extent that the child's health or emotional well-being is endangered; and

(6) engaging in any behavior having substantially the same effect on the child as that of any of the actions specified in paragraphs (e)(1) through (e)(5).

(f) "Neglect" means any act or omission resulting in harm to a child or presenting a likelihood of harm if the act or omission is not due solely to the lack of financial means of a child's parent or other custodian. This term shall include any act or omission involving a child under the age of 18 who resides in Kansas or is found in Kansas, regardless of where the act or failure to act occurred. This term shall also include any act or failure to act that occurred in Kansas, regardless of where the child is found or resides, and may include the following:

(1) Failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;

(2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or the likelihood of harm to the child;

(3) failure to use resources available to treat a diagnosed medical condition if the treatment would make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, lengthen the life span, or prevent the condition from worsening; and

(4) any behavior or omission having substan-

tially the same effect on the child as that of any of the actions specified in paragraphs (f)(1) through (f)(3).

(g) "Physical abuse" means the infliction of physical injury on a child or the causation of a child's deterioration. This term shall include any nonaccidental or intentional action or inaction that results in bodily injury or that presents the imminent risk of serious injury.

(h) "Sexual abuse" means any act committed with a child that is described in K.S.A. 21-3501 et seq. and amendments thereto and the acts described in K.S.A. 21-3602 and K.S.A. 21-3603 and amendments thereto. This term may include the following:

(1) Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person; and

(2) allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material.

(i) "Substantiated abuse or neglect" means that a report of abuse or neglect has been confirmed by clear and convincing evidence.

(j) "Substantiated perpetrator" and "perpetrator" mean a person who has been validated by the secretary or designee, using clear and convincing evidence, to have committed an act of substantiated abuse or neglect, regardless of where the person resides and, consequently, to pose a danger to children. These terms shall replace the term "validated perpetrator." (Authorized by K.S.A. 38-1523 and K.S.A. 39-708c; implementing K.S.A. 38-1523 and K.S.A. 65-516; effective Jan. 2, 1989; amended Jan. 2, 1990; amended Oct. 1, 1993; amended Jan. 1, 1997; amended Oct. 3, 1997; amended July 9, 2004.)

**30-46-11. Reporting of abuse or neglect of children who reside in an institution operated by the secretary of social and rehabilitation services.** (a) Each person who has reason to suspect that child abuse, neglect or sexual abuse, as defined in K.A.R. 30-46-10, has occurred in an institution operated by the secretary of SRS shall make a report directly to the attorney general's office and shall not be required to report first to the secretary or to any employee of the secretary except when immediate action is necessary to protect a resident or another person.

(b) Each person who has reason to suspect that

an SRS employee or a volunteer may be a perpetrator of abuse, neglect or sexual abuse, as defined in K.A.R. 30-46-10, shall not be required to make a report to the suspected perpetrator even though department policy would dictate otherwise. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1987 Supp. 65-516, as amended by L. 1988, Ch. 232, Sec. 10, L. 1988, Ch. 140; effective Jan. 2, 1989.)

**30-46-12. Standards for determining abuse, neglect or sexual abuse in a child care facility or institution.** (a) An incident may involve abuse, neglect or sexual abuse, as defined in K.A.R. 30-46-10, if, without investigation, it is more likely than not that:

(1) A child has suffered an unexplained or non-accidental injury due to an act or omission of an employee or volunteer in the facility or institution;

(2) an employee or volunteer has had sexual contact with a child;

(3) an employee or volunteer demonstrates a pattern of interaction which impairs the child's social, emotional or intellectual functioning to an observable and material degree;

(4) an employee or volunteer has failed to make a reasonable effort to prevent a child or other person from causing harm or the substantial risk of harm;

(5) an employee or volunteer has failed to make a reasonable effort to remove a child from or supervise a child in a situation that requires judgment or actions beyond the child's level of maturity, physical condition or mental ability and that results in harm or substantial risk of harm to the child;

(6) an employee or volunteer has failed to obtain or follow through with prescribed medical care for a child and such failure resulted in death, disfigurement, serious physical or emotional injury or substantial risk of same to the child; or

(7) an employee or volunteer has failed to provide a child with food, shelter or clothing necessary to sustain the life or health of the child.

(b) An incident does not necessarily involve abuse, neglect or sexual abuse, as defined in K.A.R. 30-46-10, if, without investigation, it is more likely than not that:

(1) Harm to a child resulted from an accident and was not due to wanton disregard for the welfare of the child;

(2) care provided to a child failed to meet min-



imum regulatory standards but did not result in harm or substantial risk of harm;

(3) the inappropriate use of language by an employee or volunteer did not result in emotional harm to the child;

(4) the use of inappropriate disciplinary action contrary to agency policy by an employee or volunteer has not resulted in harm or substantial risk of harm;

(5) any harm to a child resulted from the appropriate use of restraint practices approved by SRS or the department of health and environment;

(6) a child was denied privileges;

(7) harm to a child resulted from conflict with another child; or

(8) the child eloped from a facility or institution. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1987 Supp. 65-516, as amended by L. 1988, Ch. 232, Sec. 10, L. 1988, Ch. 140; effective Jan. 2, 1989.)

**30-46-13. Right to interview.** Each alleged perpetrator shall have an opportunity to be interviewed before a finding is issued substantiating a perpetrator under K.A.R. 30-46-15. (Authorized by K.S.A. 39-708c; implementing K.S.A. 38-1523, K.S.A. 39-708c, and K.S.A. 65-516; effective Jan. 2, 1989; amended Oct. 28, 1991; amended July 1, 1997; amended July 9, 2004.)

**30-46-14.** This rule and regulation shall expire on October 28, 1991. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1987 Supp. 65-516, as amended by L. 1988, Ch. 232, Sec. 10, L. 1988, Ch. 140; effective Jan. 2, 1989; revoked Oct. 28, 1991.)

**30-46-15. Notice of decision.** The substantiated perpetrator shall be notified in writing of the secretary's decision to substantiate the perpetrator for the purpose of placing the name of the perpetrator in the child abuse and neglect central registry. The notice shall set forth the reasons for the finding and shall inform the substantiated perpetrator of the perpetrator's right to appeal the decision. (Authorized by K.S.A. 39-708c; implementing K.S.A. 38-1523, K.S.A. 39-708c, and K.S.A. 65-516; effective Jan. 2, 1989; amended Oct. 28, 1991; amended July 1, 1997; amended July 9, 2004.)

**30-46-16. Child abuse and neglect central registry.** The name of a substantiated perpetrator shall not be entered into the depart-

ment's child abuse and neglect central registry until the person has exhausted or failed to exercise the appeal process in K.A.R. 30-7-64 through 30-7-104. (Authorized by K.S.A. 39-708c; implementing K.S.A. 38-1523, K.S.A. 39-708c, and K.S.A. 65-516; effective Jan. 2, 1989; amended July 1, 1997; amended July 9, 2004.)

**30-46-17. Expungement of name of perpetrator from central registry.** (a) Application for expungement.

(1) Any perpetrator of abuse or neglect may apply in writing to the secretary to have the perpetrator's name expunged from the central registry when three years have passed since the perpetrator's name was entered on the central registry or when information is presented that was not available at the time of the finding of abuse or neglect.

(2) Each application for expungement shall be referred to the expungement review panel. The panel shall consist of the commissioner of children and family services or the commissioner's designee, the chief legal counsel of the department or the counsel's designee, and a representative of the public appointed by the secretary. The commissioner of children and family services or the commissioner's designee shall chair the panel.

(3) A review hearing shall be convened by the panel, at which time the applicant may present evidence supporting expungement of the applicant's name from the central registry. Evidence in support of or in opposition to the application may be presented by the regional office that conducted the original investigation. A request for expungement from a perpetrator shall receive a hearing by the review panel only once every 12 months.

(4) Recommendations of the review panel shall be determined by majority vote. The following factors shall be considered by the panel in making its recommendation:

(A) The nature and severity of the act of abuse or neglect;

(B) the number of findings of abuse or neglect involving the applicant;

(C) if the applicant was a child at the time of the finding of the abuse or neglect for which expungement is requested, the age of the applicant at the time of this occurrence;

(D) circumstances that no longer exist that contributed to the finding of abuse or neglect by the applicant; and

(E) actions taken by the applicant to prevent the reoccurrence of acts of abuse or neglect.

(5) The review hearing shall be set within 30 days from the date the application for expungement is received by the department. A written notice shall be sent to the applicant and the regional office that made the finding by the director of children and family services or the director's designee at least 10 days before the hearing. The notice shall state the day, hour, and place of the hearing. Continuances may be granted only for good cause.

(6) A written recommendation to the secretary shall be rendered by the panel within 60 days from the date of the hearing. The decision of the secretary shall be in writing and shall set forth the reasons for the decision.

(b) Expungement by the secretary. Any record may be expunged from the central registry by the secretary or the designee of the secretary when 18 years have passed since the most recent finding of abuse or neglect. (Authorized by K.S.A. 39-708c; implementing K.S.A. 38-708c and K.S.A. 65-516; effective Jan. 2, 1989; amended Jan. 1, 1990; amended July 1, 1997; amended July 9, 2004.)

#### **Article 47 to 50.—RESERVED**

#### **Article 51.—ADULT ABUSE, NEGLECT OR EXPLOITATION**

**30-51-1 to 30-51-5.** These rules and regulations shall expire on April 1, 1990. (Authorized by and implementing K.S.A. 39-708c, 39-1422; effective, T-88-59, Dec. 16, 1987; effective May 1, 1988; revoked April 1, 1990.)

#### **Article 52 to 59.—RESERVED**

#### **Article 60.—LICENSING OF COMMUNITY MENTAL HEALTH CENTERS**

**30-60-1. Scope.** The regulations set forth in this article shall provide for the licensing of, and set the standards for the services and programs required of, community mental health centers, including the following:

(a) Each center organized as a community mental health center pursuant to the provisions of K.S.A. 19-4001 et seq., and amendments thereto;

(b) each center organized as a mental health clinic pursuant to the provisions of K.S.A. 65-211 et seq., and amendments thereto; and

(c) each affiliated center meeting the exception specified in K.S.A. 75-3307b(b), and amendments thereto. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 75-3307b, 75-3307c, and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-2. Definitions.** Words and phrases used in this article but not defined in this regulation shall have the same meanings as they are defined to have in the “care and treatment act for mentally ill persons,” K.S.A. 59-2945 et seq., and amendments thereto, or in the “mental health reform act,” K.S.A. 39-1601 et seq., and amendments thereto. (a) “Affiliate” means any individual or agency that independently provides mental health services and that has entered into an affiliation agreement with a community mental health center in accordance with the provisions of K.A.R. 30-60-29.

(b) “Affiliated center” means any community mental health center that is licensed by the secretary in accordance with this article, based upon the exception specified in K.S.A. 75-3307b(b) and amendments thereto.

(c) “Center” means a community mental health center that is organized pursuant to K.S.A. 19-4001 et seq., and amendments thereto, or K.S.A. 65-211 et seq., and amendments thereto, and that is licensed by the secretary in accordance with this article. This term shall not include any “affiliated center” that is licensed by the secretary in accordance with this article, based upon the exception specified in K.S.A. 75-3307b(b) and amendments thereto.

(d) “Consumer” means a person, whether a child, an adolescent, or an adult, who is in need of, is currently receiving, or has recently received any services from any mental health services provider. This term shall include, when appropriate in the context, the spouse of an adult consumer, the legal guardian of a consumer, the parent of a minor who is a consumer, the foster parent of a minor who is the subject of juvenile court proceedings, other members of the immediate family of a minor who is a consumer, and other individuals, including members of the immediate family of an adult consumer, who may be living with or assisting, or are otherwise being supportive of a consumer.

(e) “Contractor” means any individual or agency providing any service to a licensee in accordance with a contract, whether written or oral,

entered into by the licensee and the contractor. This term shall not include a licensee. A “contractor” may also be an “affiliate” if the individual or agency has entered into an affiliation agreement with a center in accordance with the provisions of K.A.R. 30-60-29.

(f) “Department” means the department of social and rehabilitation services.

(g) “Division” means the division of mental health, addiction and prevention services within the department of social and rehabilitation services.

(h) “Executive director” means the individual appointed by a licensee in compliance with K.A.R. 30-60-40(a), regardless of whether that individual has been given any other title by the licensee. This term shall include, when appropriate, the designee of the executive director.

(i) “Licensee” means either a community mental health center licensed by the secretary in accordance with this article, or an “affiliated center” licensed by the secretary in accordance with this article. This term shall not include an “affiliate” or a “contractor.”

(j) “Secretary” means the secretary of social and rehabilitation services. This term shall include, when appropriate, the assistant secretary for health care policy. (Authorized by K.S.A. 39-1603(t), 75-3307b; implementing K.S.A. 39-1603(t), 75-3304a, and 75-3307b; effective Oct. 28, 1991; amended July 7, 2003.)

#### **30-60-3 and 30-60-4. Reserved.**

**30-60-5. Two types of license; requirements.** (a) Two types of license shall be issued by the secretary in accordance with this article. One shall be titled “community mental health center.” The other shall be titled “affiliated community mental health center.” To be eligible for either license, the applicant agency shall demonstrate that it can and will comply with all of the applicable requirements contained within this article. However, the applicant agency shall not be required to meet the requirements contained within article 61 that provide for those additional services and programs that a center must be capable of and willing to provide in order to be eligible to contract with the secretary to become a participating community mental health center.

(b) (1) Only one license shall be issued by the secretary to operate a “community mental health center” within a designated service area, which shall be stated upon the license issued.

(2) If the board of county commissioners for any county within the service area of a licensed center, pursuant to K.S.A. 19-4001 and amendments thereto, notifies the secretary of the board’s withdrawal of its designation of that licensed center as the community mental health center for that county and requests that the secretary either approve the establishment of a new community mental health center for that county, as provided for in K.A.R. 30-60-10, or approve the realignment of the service area of another existing licensed center to include that county within its service area, as provided for in K.A.R. 30-60-12, and if the secretary approves either request, then at least one of the following actions shall be taken by the division:

(A) If the secretary’s action involves the establishment of a new community mental health center to replace the existing licensed center and that existing center will not afterwards be serving any other county, the license of the existing center from which the board of county commissioners withdrew its designation shall be revoked.

(B) If the secretary’s action involves the realignment of the service area of one or more existing licensed centers, a new license shall be issued to each involved center. Each new license shall state upon it the new service area of that center.

(c) Each agency meeting the exception specified in K.S.A. 75-3307b(b), and amendments thereto, shall be exempted from the limitation stated in subsection (b) above and may be licensed as an “affiliated community mental health center,” if it complies with all of the following:

(1) The agency has an affiliation agreement, as specified in K.A.R. 30-60-29, with each center within whose service area the agency provides any services.

(2) The agency makes regular and timely applications for renewal of its license.

(3) The agency is at all times in compliance with all of the applicable requirements of this article, including those applicable to the services and programs it has agreed to provide in its affiliation agreement with any center. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 75-3307b, 75-3307c, and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-6. Licensing procedure; compliance surveys; duration and renewal of license; provisional license.** (a) Each agency or licensee desiring a new or renewed license as a

“community mental health center” or an “affiliated community mental health center” shall submit an application for that license, or for renewal of its license, to the secretary in the format prescribed by the division. Each application for renewal of a license shall be submitted at least 45 days before the expiration of the current license. This requirement may be waived by the secretary upon a showing of good cause. If a waiver is granted, a reasonable deadline may be established by the secretary for submittal of the required renewal application.

(b) Upon receipt of an application for a license or for renewal of a license, a survey of the applicant agency or licensee may be conducted by the division to determine whether the applicant agency or licensee is in compliance with the applicable requirements of this article or can be expected to be in compliance with the applicable requirements of this article during the term of the requested license.

(c) At any time deemed appropriate by the division, a licensee may be formally resurveyed by the division to determine whether the licensee continues to be in compliance with the requirements of this article. No prior notice by the division of its intent to conduct a continuing compliance survey shall be required to be given to a licensee. Neither technical assistance provided to a licensee nor ongoing monitoring of a licensee’s programs and services by any employee of the division assigned by the department to perform quality assurance duties shall be construed to constitute a formal resurvey for compliance under this subsection. However, if an employee of the division observes any evidence of noncompliance with the requirements of this article by a licensee, a compliance resurvey under this subsection may be instituted.

(d) Following any initial, renewal, or continuing compliance survey, the applicant agency or licensee shall be notified of the division’s findings in writing. Any applicant agency or licensee that disagrees with any finding of the division that the applicant agency or licensee is not in compliance with an applicable requirement of this article may submit, in writing and within 15 days of receipt of the division’s survey findings, any arguments and supporting documents that the applicant agency or licensee wishes the division to consider. These written materials shall become a part of the record concerning the agency’s application for a license or application for renewal of its license. Based

upon these materials, a determination may be made by the division to resurvey the applicant agency or licensee or to revise the division’s survey findings. If a resurvey or revision of the division’s findings is made, the applicant agency or licensee shall be notified of the division’s new findings, in writing.

(e) Upon receipt of an application for a license or for renewal of a license, or following any initial, renewal, or continuing compliance survey, a recommendation for the issuance of a provisional license to begin or continue operations by an applicant agency or licensee may be made to the secretary by the division. Each provisional license issued shall include the requirement that the applicant agency or licensee develop, submit, and implement a plan of corrective action to bring the applicant agency or licensee into compliance with the applicable requirements of this article.

(1) This plan of corrective action shall be submitted to the division within 30 days following receipt by the applicant agency or licensee of the division’s written request for a plan of corrective action.

(2) The plan of corrective action shall be reviewed by the division to determine the following:

(A) Whether the plan adequately addresses all of the areas of noncompliance cited in the division’s survey report; and

(B) whether a follow-up resurvey is necessary to determine that the plan has been fully implemented and that the applicant agency or licensee is in compliance with the applicable requirements of this article. No prior notice by the division of its intent to conduct a resurvey shall be required to be given to the applicant agency or licensee.

(3) The division’s findings from any follow-up resurvey shall be provided to the applicant agency or licensee, in writing, and may include a recommendation to the secretary that a license be issued, that the application be denied, that a license be revoked, or that further corrective action be taken by the applicant agency or licensee.

(4) Failure of an applicant agency or licensee to submit or to fully implement an acceptable plan of corrective action may be grounds for denial or revocation of a license, regardless of whether or not a provisional license has been recommended or issued.

(f) (1) If the division determines upon receipt of an application for a license, an application for renewal of a license or a plan of corrective action, that no compliance survey or resurvey is neces-



sary, a recommendation may be made by the division to the secretary that the applicant agency or licensee merits the public's trust and that a license should be issued for a specified term.

(2) If a compliance survey or resurvey finds that the applicant agency or licensee is in compliance with the applicable requirements of this article, or can be expected to be in compliance with the applicable requirements of this article during the term of the requested license, a recommendation may be made by the division to the secretary that the applicant agency or licensee merits the public's trust and that a license should be issued for a specified term.

(3) If a compliance survey or resurvey does not find that the applicant agency or licensee is in compliance with the applicable requirements of this article, or can not be expected to be in compliance with the applicable requirements of this article during the term of the requested license, or if the division determines that the applicant agency or licensee does not merit the public's trust, a recommendation may be made by the division to the secretary that the application should be denied. A copy of any recommendation made by the division to deny a license, or to deny renewal of a license, shall be sent to the applicant agency or licensee by registered mail and addressed to the executive director of the applicant agency or licensee, and shall clearly state the reasons for the recommended denial. Any recommendation for denial of a license, or denial of renewal of a license, may be appealed to the office of administrative hearings within the Kansas department of administration in accordance with article 7.

(g) Each license issued by the secretary in accordance with this article shall be in effect for a term to be stated upon the license, which shall not exceed two years, unless revoked earlier for cause.

(h) Each provisional license issued by the secretary shall specify the length of time for which it shall be valid, but in no case shall a provisional license be valid for more than six months. Successive provisional licenses may be issued. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 75-3307b, 75-3307c, and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-7. Suspension; revocation of a license; procedure; voluntary surrender.** (a) Any license issued by the secretary in accordance with this article may be suspended or revoked for

failure of the licensee to be in compliance with the applicable requirements of this article.

(b) A license may be suspended only upon a determination by the division that continued operations by the licensee during any license revocation proceedings would constitute a serious threat to the health and safety of consumers receiving the licensee's services. A copy of this determination shall be provided to the licensee, in writing, and shall clearly state the reasons for it.

(c) Before revocation of a license, a written notice of the proposal to revoke the license shall be sent by registered mail to the executive director of the licensee, along with a copy of the division's determination to suspend the license during the revocation proceedings, if applicable. The notice shall include the following:

(1) A clearly written statement of the reasons for the proposed revocation of the license;

(2) the date upon which the revocation of the license will become effective, unless appealed; and

(3) notice to the licensee that this proposal to revoke its license may be appealed to the office of administrative hearings within the Kansas department of administration in accordance with article 7.

(d) If, at any time during the pendency of revocation proceedings, the division is satisfied that the licensee is in compliance with all of the applicable requirements of this article and that it is in the best interests of the public that the proposed revocation be withdrawn, all parties to the revocation proceedings shall be notified by the division that the proposed revocation has been withdrawn. The revocation proceedings shall then be terminated.

(e) If, after notice to the licensee of a proposed revocation, the licensee does not timely appeal the proposed revocation, or at the conclusion of any revocation proceedings that result in the proposed revocation being upheld, the following actions shall be taken:

(1) The license previously issued shall be revoked by the division.

(2) The board or boards of county commissioners of each county within the service area of any center whose license has been revoked shall be notified by the division of the revocation and of the procedures by which the board or boards of county commissioners may establish a new community mental health center.

(f) A licensee may at any time voluntarily sur-

render its license. Upon a voluntary surrender of a license, the license shall be marked by the division as void. The board or boards of county commissioners of each county within the service area of any center that voluntarily surrenders its license shall be notified by the division of the licensee's voluntary surrender of the license and of the procedures by which the board or boards of county commissioners may establish a new community mental health center.

(g) If the division has revoked a license previously issued, or a licensee has voluntarily surrendered its license, the licensee may be required by the division to develop and implement a plan for the transfer of those consumers then receiving any services from the licensee to another licensed or other appropriate provider of these services. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-8. Notice of need of a license; order to cease; appeal.** (a) Upon the division's notice to any person or agency of the division's determination that the person or agency is providing services for which a license issued in accordance with this article is required, that person or agency shall either submit an application for the applicable license in accordance with K.A.R. 30-60-6 or cease provision of those services.

(b) If any person or agency so notified fails or refuses to submit, within 60 days, an application for the applicable license but continues to provide the services, a written order addressed and delivered to that person or agency may be issued by the division, requiring the person or agency to cease provision of those services until the person or agency is licensed in accordance with this article.

(c) Any order to cease provision of services may be appealed to the office of administrative hearings within the Kansas department of administration in accordance with article 7. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)

**30-60-9. Reserved.**

**30-60-10. Establishment of a new community mental health center; altered service area.** (a) Pursuant to K.S.A. 19-4001 and amendments thereto, the establishment of a new com-

munity mental health center shall not be approved by the secretary if the proposed center's service area is already being served by one or more existing licensed centers, unless the respective board or boards of county commissioners notify the secretary of the following:

(1) The intent of the board or boards to withdraw their designation of the existing licensed center serving that area as their community mental health center; and

(2) the request of the board or boards that the secretary approve the establishment of a new community mental health center, as requested in accordance with K.A.R. 30-60-11.

(b) No licensed center may alter its existing service area to include an area already being served by one or more other licensed centers, except in compliance with subsection (a) and K.A.R. 30-60-11.

(c) Each proposal to establish a new community mental health center to serve an area not then being served by a licensed center shall be accompanied by an application for a license as a community mental health center as required by K.A.R. 30-60-6. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-11. Necessary elements for a proposal to establish a new community mental health center or to realign the service area of one or more existing centers.** (a) A written request for approval of the establishment of a new community mental health center, or of the realignment of the service area of any licensed center, shall be made by the respective board or boards of county commissioners to the secretary, pursuant to K.S.A. 19-4001 and amendments thereto, and shall include, or contain as an attachment, the following:

(1) The rationale for the proposal;

(2) a specific plan for providing mental health services to persons living within the proposed new service area;

(3) an endorsement of the proposal by the governing boards and executive directors of any licensed centers that might be affected by the proposal, as appropriate;

(4) any written comments that have been received from other governmental agencies existing within any affected service area; and

(5) any written comments received from the

public and a summary of any public comments made at a public hearing held for the purpose of receiving comments on the proposal. The division shall be consulted in advance of this public hearing and shall have approved of the procedures utilized in obtaining the public comments.

(b) The rationale for the proposal shall include the following:

(1) Information about how, and by whom, the decision to create the proposed new community mental health center or to realign the licensed center's service area was initiated;

(2) a map of the service area or areas proposed to be created;

(3) a statement describing the problems thought to exist with the provision of mental health services within this area; and

(4) information about how the proposed community mental health center or the realignment of any licensed center's service area will address these problems.

(c) The plan for providing mental health services shall include the following:

(1) A description of how the services required by this article to be provided by a community mental health center, and any other planned services, will be provided by the proposed new community mental health center or by the realigned center;

(2) a description of any unique mental health needs of the community within the proposed service area and the manner in which those needs will be met by the proposed new community mental health center or realigned center;

(3) evidence of the establishment of a working relationship between the proposed new community mental health center or realigned center and the local district court, other local providers of mental health services, and the applicable state hospital, as designated in K.A.R. 30-26-1a;

(4) a plan for adequate staffing of the proposed new community mental health center or realigned center;

(5) a description of the planned structure of governance, organization, and management of the proposed new community mental health center or the realigned center;

(6) a financial plan detailing how the proposed new community mental health center or the realigned center will be financed during an initial five-year period; and

(7) a statement of the anticipated fiscal and service impacts that the creation of this proposed

new community mental health center, or the realignment of the licensed center, would have on all other affected service areas. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-12. Approval or disapproval of a proposal to establish a new community mental health center or to realign the service area of one or more existing centers.**

(a) Each proposal to establish a new community mental health center, or to realign the service area of one or more licensed centers, and the materials required to be submitted to the secretary by K.A.R. 30-60-11 shall be reviewed by the division to determine whether or not the proposal contributes to the state's overall plan for providing mental health services. Additional comments from the following may be received or sought out by the division:

(1) Other divisions within the department;

(2) appropriate representatives of the district court for the proposed service area or areas;

(3) consumer organizations;

(4) representatives or advocates of consumers; and

(5) other individuals or agencies as the division deems appropriate.

(b) The approval or disapproval of the proposal may be recommended to the secretary by the division. The proposer shall be notified by the division of that recommendation in writing. If the division recommends disapproval of the proposal, the notification shall clearly state the reasons for this recommendation.

(c) Any recommendation to the secretary that the proposal be disapproved may be appealed to the office of administrative hearings within the Kansas department of administration in accordance with article 7. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-13. Responsibility for compliance.** (a) Each center shall comply with the requirements of this article.

(b) Each center shall ensure compliance with the applicable requirements of this article by any affiliated center, affiliate, or contractor with which the center has entered into an affiliation agreement or contract to provide any service specified in this article. (Authorized by K.S.A. 39-1604(r),

75-3307b; implementing K.S.A. 39-1603(r), 75-3307b, and 75-3304a; effective July 7, 2003.)

**30-60-14. Departmental assistance; co-operation with compliance monitoring.** One or more employees of the division may be assigned by the department to provide technical assistance to a licensee or to assist a licensee in developing its quality improvement program or other similar responsibilities. Each licensee shall cooperate with that employee's efforts and with that employee's monitoring of the licensee's ongoing compliance with the requirements of this article. This cooperation shall include providing that employee with reasonable access to all of the facilities and administrative records of the licensee and to all clinical records and treatment or service activities of the licensee. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)

**30-60-15. Access; identification; information.** (a) Each center shall make every reasonable effort to overcome any barriers that consumers may have to receiving services, including the following:

- (1) Physical disabilities;
- (2) disabilities specifically resulting from any mental illness;
- (3) language or other communication barriers;
- (4) barriers associated with cultural, social, ethnic, and religious factors; and
- (5) barriers associated with economic issues, including a consumer's access to public transportation, child care needs, and the demands of the consumer's employer.

(b) Each center shall make the following information generally known to or easily discoverable by the public:

- (1) The address and location of the center;
- (2) the center's usual office hours;
- (3) the center's telephone number, including any telephone number that should be called in an emergency; and
- (4) the types of services provided by the center or its contractors, or by any affiliated center or affiliate with which the center has an affiliation agreement. Each center shall make an effort to advertise the center's services, the services of any affiliated center or affiliate with which the center has an affiliation agreement, and the availability of those services, at locations where consumers are likely to be found.

(c) If a center is physically located within a multiuse or multipurpose building, the center shall insure that the center can be found within that building by having posted, both outside and inside of the building, signs or other directory information sufficient to assist consumers to locate the center.

(d) Each center shall make available at the center, and at other appropriate locations, materials that provide information about the following:

- (1) A description of the center and the services that the center or its contractors provide;
  - (2) a description of any affiliated center or affiliate with which the center has an affiliation agreement and the services that each provides;
  - (3) the rights of consumers;
  - (4) the center's policy on fees and adjustments to those fees; and
  - (5) the ways to contact the center for services.
- (e) The materials specified in subsection (d) shall be designed to be comprehensible to persons with only a limited education.

(f) All center stationery used to communicate with the public and any preprinted materials prepared for use in communicating with consumers shall have printed on that stationery and those materials the center's name, address, and telephone number, including any telephone number that should be called in an emergency. (Authorized by K.S.A. 39-1603(r), 65-4434(f), and 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 65-4434(f), 75-3307b, and 75-3304a; effective July 7, 2003.)

**30-60-16. No denial of required services; exceptions; requirements; rights, documentation.** (a) No center shall deny necessary and appropriate services to any person requesting mental health services from that center unless any of the following conditions is met:

(1) The person requires services that are not required by K.A.R. 30-60-64 to be provided by a center and that are not provided by the center.

(2) The person refuses to pay the fees charged for any services provided, even after those fees have been adjusted or reduced in compliance with K.A.R. 30-60-17, unless the center is required by K.A.R. 30-60-64 to provide those services.

(3) The person is determined by the executive director to have engaged in behavior that threatens the safety of center staff or other individuals present at the center, but only if every reasonable effort has been made to address those issues. The



denial of services may continue only as long as the behavior continues.

(b) If a center denies any necessary and appropriate services to any person, the center shall take one or more of the following actions, as applicable:

(1) (A) If the services being denied are services that are required by K.A.R. 30-60-64 to be provided by a center, immediately send to the division the name and address of that person, a list of what specific services are being denied, and the reasons why this denial has been instituted; and

(B) refer the person to another mental health services provider with whom the center has made arrangements for the provision of those services to that person, including, if the other provider requires it, arrangements for the other provider to be paid for its services by the center;

(2) if the services being denied are services not required by K.A.R. 30-60-64 to be provided by a center, refer the person to another appropriate provider; or

(3) if the person is engaging in threatening behavior, either initiate the appropriate involuntary admission of that person to a state psychiatric hospital or to another appropriate treatment facility, or take other appropriate actions necessary to ensure the safety of both that person and other individuals, including, when necessary, calling the appropriate law enforcement agency.

(c) Each person who has been denied any services by a center shall have the right to file a complaint concerning that denial, as specified in K.A.R. 30-60-51, and shall be informed of the procedures and process of filing a complaint. The center shall document its compliance with this requirement. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)

**30-60-17. Prohibition against denial of required services because of an inability to pay fees; establishment of a schedule of fees; adjustment; disclosure; reviews; collection of fees.** (a) No center shall deny to any consumer requesting services from that center any necessary and appropriate services that the center is required to provide by K.A.R. 30-60-64, solely because of the consumer's inability to pay the fees charged by the center for those services, even after those fees have been adjusted or reduced in compliance with this regulation.

(b) Each center shall print upon all center stationery used to communicate with the public and any preprinted materials prepared for use in communicating with consumers a statement indicating that the center will not deny to any consumer necessary and appropriate services that the center is required by K.A.R. 30-60-64 to provide, solely because of the consumer's inability to pay the fees charged by the center for those services. This statement shall also indicate that the fees charged by the center may be adjusted or reduced in compliance with this regulation.

(c) Each licensee shall periodically establish the fees that the licensee charges for its services. These fees shall be published in a schedule of fees, which shall be made available to anyone upon request.

(d) Each licensee shall adopt and adhere to written policies and procedures specifying when staff shall have the authority to adjust from the published schedule of fees the actual fee that will be charged for any service provided to any consumer. These policies and procedures shall require that a consumer's ability to pay that fee, or any responsible party's ability to pay that fee, shall be considered in making any adjustments. These policies and procedures shall further specify the circumstances in which the services provided by the licensee would be provided to a consumer free of any charge.

(e) Each licensee shall perform the following:

(1) Require its staff to disclose to any consumer seeking services from the licensee that licensee's schedule of fees for those services, and the policies and procedures under which designated staff members have the authority to adjust those scheduled fees; and

(2) require its staff to periodically review the circumstances of every consumer receiving services from the licensee to determine whether any adjustments to the fees being charged that consumer should be made.

(f) Each licensee shall adopt and adhere to written policies and procedures providing for the collection of fees to which the licensee is entitled but that remain unpaid after they are due. These policies and procedures shall include the following:

(1) Requiring staff to document the efforts undertaken to collect any fees that have not been paid when due;

(2) specifying under what circumstances any past-due charges may be reduced or forgiven;

(3) providing that any individual responsible for paying any past-due charges may request that the licensee reduce or forgive all or part of those past-due charges; and

(4) providing that any consumer whose request that past-due charges be reduced or forgiven is denied shall have the right to file a complaint concerning that denial, as provided for in K.A.R. 30-60-51, and shall be informed of the procedures and process of filing a complaint.

(g) Each licensee shall document its compliance with the requirements of this regulation. (Authorized by K.S.A. 39-1603(r), 75-3307b; implementing K.S.A. 39-1603(r), 75-3307b, and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-18. Coordination and community involvement.** Each center, in order to facilitate the coordination of services between itself and other agencies and the referral of consumers, both to the center by others and by the center to other providers of services, shall establish and maintain cooperative working relationships with those local public and private agencies who are also likely to provide services to consumers, including the following:

(a) The department of social and rehabilitation services local area office and any applicable divisions or contractors of the department;

(b) public health agencies, public and private hospitals and clinics, other health care providers, and providers of specialized mental health services, including private mental health treatment facilities, nursing facilities for mental health, and residential care facilities for the mentally ill;

(c) community developmental disability organizations and community mental retardation and developmental disabilities service providers;

(d) the local regional alcohol and drug abuse assessment center and other treatment agencies for alcohol or substance abuse;

(e) public and private schools and other education agencies;

(f) law enforcement agencies, including jails and other adult detention facilities;

(g) the district court for each county within the service area of the center;

(h) juvenile justice agencies, including juvenile detention facilities;

(i) public housing authorities;

(j) area agencies on aging;

(k) employment service agencies;

(l) homeless shelters; and

(m) agencies run by or specifically oriented to consumers. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-19. Data and statistical reporting.**

(a) Each center shall compile and report to the division data and statistics concerning the operations of the center and its utilization by the community as the division may require.

(b) These data and statistical reporting requirements shall be developed by the division after consultation with the association of community mental health centers, inc. and other parties as the division deems appropriate. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-20 to 30-60-24. Reserved.**

**30-60-25. Governing or advisory board; powers; bylaws.** (a) Each center shall have a governing board empowered to perform the following:

(1) Adopt bylaws and establish policies and procedures for the center;

(2) set goals and adopt necessary plans and a budget for the center; and

(3) exercise general supervisory authority over the center, including having the authority to hire, evaluate, and fire the executive director of the center, appointed in compliance with K.A.R. 30-60-40.

(b) If, pursuant to K.S.A. 19-4002a or 19-4002b, and amendments thereto, the board of county commissioners acts as the governing board for their center, then the advisory board, pursuant to K.S.A. 19-4002a or 19-4002b, and amendments thereto, shall be empowered to make recommendations to the board of county commissioners concerning the same matters as those listed in subsection (a).

(c) The membership of the governing or advisory Board shall meet the following criteria:

(1) Consist of no fewer than seven members;

(2) include among them at least one member who is currently being treated for or who has in the past experienced a severe and persistent mental illness. In addition, a second member shall be included who is a member of a family that has a

child or adolescent who is currently being treated for or who has in the past experienced a severe emotional disability or disorder;

(3) to the extent possible, and over time and in rotation, both be representative of the various communities within the center's service area, and include representatives from the following groups within the community:

- (A) Public health agencies;
- (B) medical professionals;
- (C) legal professionals and district court judges;
- (D) public assistance agencies;
- (E) hospitals and clinics, including any psychiatric treatment facilities;
- (F) mental health organizations;
- (G) educational agencies;
- (H) rehabilitation services agencies;
- (I) labor and business organizations;
- (J) civic groups and organizations;
- (K) consumer-run organizations and advocacy groups; and
- (L) the general public.

(d) The governing or advisory board shall meet at least quarterly, and comprehensive minutes of all meetings of the board shall be kept.

(e) Each center's bylaws and its other policies and procedures shall meet the following criteria:

- (1) Provide for the governance of the board, the terms of office of its members, and the election of their successors;
- (2) clearly set out and differentiate the responsibilities, authorities, and roles of the following:
  - (A) The governing or advisory board;
  - (B) the executive director; and
  - (C) other staff of the center; and
- (3) establish how the center shall operate.

(f) If a center is operated as a governmental agency or is operated as a department of a hospital, the bylaws shall include provisions establishing and delineating the lines of authority between the superior governmental authority or the hospital's ownership and the governing or advisory board of the center.

(g) If the center is organized as a private, non-profit corporation, it shall meet the following criteria:

- (1) Be incorporated pursuant to Kansas statutes;
- (2) be duly registered with the secretary of state and the register of deeds for the county in which the principal office of the center is located;
- (3) pursuant to K.S.A. 19-4007 and amend-

ments thereto, file its written contract for providing mental health services to the residents of that county or counties with the board or boards of county commissioners of the county or counties it serves; and

(4) adopt bylaws, which shall include the following:

(A) A delineation of the powers and duties retained by the corporation's board, its officers, and any committees;

(B) a delineation of the authority and responsibilities delegated to the corporation's employed staff;

(C) the criteria for membership in the corporation, the types of membership that there are, the manner in which the members are elected or appointed, the length of term of membership, and the method of filling vacancies in the membership;

(D) the frequency of corporation meetings and quorum requirements;

(E) the objectives of the corporation; and

(F) other items that may be appropriate or necessary to demonstrate how the corporation is organized, operates, and selects its officers. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-26. Conflict of interest prohibited.** Each licensee shall ensure that no individual serving on the licensee's governing or advisory board or as an employee, contractor, or consultant engages in activities constituting a conflict of interest between the licensee's provision of services and the private, remunerative activities of that individual, employee, contractor, or consultant. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-27. Annual audit.** (a) Each center shall annually obtain an independent audit of the financial affairs and records of the center.

(b) The reports of this audit shall be made available to anyone upon request.

(c) A copy of the two most recently completed audit reports shall be attached to the center's application for renewal of its license, submitted to the division in accordance with K.A.R. 30-60-6, unless previously provided to the division in accordance with K.A.R. 30-60-19 or any separate

grant or contract compliance requirement. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-28. Mission and vision statements; strategic plan; coordination with quality improvement program.** (a) Each center shall develop, adopt, and display at appropriate locations a statement of its mission, including a concise statement of the purpose for which the center exists, the general nature of the services it provides, and the population to whom it provides those services.

(b) Each center shall develop and adopt a vision statement of its goals for the future and the values it holds with regard to the consumers it serves.

(c) Each center shall develop and adopt a statement of its strategic plan, including specific, measurable, short-term, and long-term goals, and the specific means or methods by which it intends to accomplish those goals.

(d) Each center shall ensure consistency between its strategic plan and its quality improvement program required by K.A.R. 30-60-55. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-29. Affiliation agreement; notice to secretary of a center's refusal to enter into; investigation and recommendations; no agreement imposed.** (a) Each center shall have a written affiliation agreement with each affiliated community mental health center that is licensed by the secretary in accordance with this article based upon the exception provided for in K.S.A. 75-3307b(b), and amendments thereto, and that provides any of the services described in this article within the service area of that center. Any center may enter into an affiliation agreement with any other provider of mental health services with which the center chooses to enter into an affiliation agreement.

(b) Each affiliation agreement shall contain the following:

(1) A description of the types of services that the affiliated center or other provider has agreed to provide, pursuant to the terms of the affiliation agreement;

(2) provisions concerning how and by what

procedures a consumer requesting or receiving services from the center can be referred to the affiliated center or other provider;

(3) provisions concerning how and by what procedures a consumer requesting or receiving services from the affiliated center or other provider can or should be referred to the center;

(4) any necessary and appropriate financial arrangements between the center and the affiliated center or other provider;

(5) provisions concerning how and by what procedures the affiliated center or other provider will assist the center in the collection of any data or statistics that the center may require in order to comply with K.A.R. 30-60-19;

(6) a statement that the affiliated center or other provider agrees to provide any of the services it provides in a manner consistent with the mission statement of the center and that the affiliated center or other provider accepts and will abide by the values of the center. This statement shall include a description of how the services that are to be provided by the affiliated center or other provider will augment or supplement the services of the center or how those services will promote the strategic plan of the center adopted in compliance with K.A.R. 30-60-28;

(7) an agreement specifying that the affiliated center or other provider is subject to and will abide by and utilize the policies and procedures that the center adopts in compliance with K.A.R. 30-60-30, concerning the solicitation of consumer comments and suggestions;

(8) an agreement specifying that the affiliated center or other provider is subject to and will abide by and utilize the policies and procedures that the center adopts in compliance with K.A.R. 30-60-48, concerning de-escalation techniques and emergency behavioral interventions;

(9) an agreement specifying that the affiliated center or other provider is subject to and will abide by and utilize the policies and procedures that the center adopts in compliance with K.A.R. 30-60-51, concerning accepting and resolving complaints;

(10) an agreement specifying that the affiliated center or other provider is subject to and will abide by and utilize the policies and procedures that the center adopts in compliance with K.A.R. 30-60-55, concerning the center's quality improvement program;

(11) an agreement specifying that the affiliated center or other provider is subject to and will



abide by and utilize the policies and procedures that the center adopts in compliance with K.A.R. 30-60-56, concerning the center's risk management program;

(12) an agreement specifying that the affiliated center or other provider is subject to and will abide by and utilize the policies and procedures that the center adopts in compliance with K.A.R. 30-60-57, concerning the center's utilization review program; and

(13) provisions specifying when and under what circumstances the affiliation agreement either expires or can be cancelled.

(c) (1) If a center refuses to enter into an affiliation agreement with either of the following types of agencies, the agency may notify the secretary of that refusal:

(A) Any agency that wishes to become an affiliated provider and that would otherwise be entitled to any benefits that would be associated with being an affiliate of a community mental health center; or

(B) any agency that would otherwise be entitled to a license as an affiliated community mental health center by virtue of the exception specified in K.S.A. 75-3307b(b) and amendments thereto.

(2) Upon notification of a center's refusal to enter into an affiliation agreement, the division or any other individual or agency may be requested by the secretary to investigate the circumstances leading to this refusal and to make recommendations to either or both parties. (Authorized by K.S.A. 75-3307b(b); implementing K.S.A. 75-3307b(b) and 75-3304a; effective July 7, 2003.)

**30-60-30. Solicitation and consideration of consumer comments and suggestions.** (a) Each center shall adopt and adhere to written policies and procedures that provide for regular and ongoing solicitation of comments and suggestions from its consumers. Each center shall utilize both formal and informal means of soliciting these comments or suggestions and shall ensure the solicitation of a diverse group of consumers to whom the center, and each affiliated provider with which the center has an affiliation agreement, provides services.

(b) Each center shall ensure coordination between the solicitation of consumer comments and suggestions and its quality improvement program required by K.A.R. 30-60-55.

(c) Records that demonstrate each center's compliance with this requirement shall be cen-

trally maintained for at least five years. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)

### **30-60-31 to 30-60-39. Reserved.**

**30-60-40. Personnel.** (a) Each licensee shall vest the following duties in an executive director, to be appointed by and responsible to the governing board of a center, or as provided for in the bylaws or other policies and procedures of an affiliated provider:

(1) Responsibility for the day-to-day operations of the licensee;

(2) assurance of the quality of the services provided; and

(3) the effective and efficient management of the licensee's resources.

(b) The medical responsibility for any consumer to whom the licensee provides services shall be vested in a licensed physician. If the physician is not a psychiatrist, then a psychiatric consultant shall be made available to this physician and to other staff assigned to work with that consumer on a continuing and regularly scheduled basis.

(c) Each licensee shall provide its services using appropriately trained or professionally qualified staff. Each licensee shall ensure that it retains the services of sufficient staff to appropriately meet the needs of those consumers to whom the licensee is providing any services. All treatment shall be provided by, or provided under the direction or supervision of, professionally qualified staff.

(d) Each licensee shall ensure that its professional staff meets any applicable state licensing, registration, or certification requirements and has completed any training program that may be required by the division within the contract, if any, in accordance with K.A.R. 30-61-5, that the department has with the center or with the center with which the licensee is affiliated.

(e) Each licensee shall ensure that any staff providing any community-based services outside of the offices of the licensee have completed, or will have completed within six months, a community services training program approved by the division.

(f) Each licensee shall insure that any volunteers or students providing any services to any person are screened, trained, and regularly super-

vised in accordance with written policies and procedures, which shall meet the following criteria:

(1) Govern the scope and extent of volunteer or student participation in any treatment being provided; and

(2) require training that shall include a review of the center's policies and procedures regarding confidentiality and consumer rights. (Authorized by 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-41. Personnel policies and procedures.** (a) Each licensee shall adopt and adhere to written personnel policies and procedures providing for the rights, duties, and responsibilities of all members of the licensee's staff.

(b) These policies and procedures shall require the following, at a minimum:

(1) That a written job description exist for each position and that it be reviewed by supervisory staff with the employee and revised on a regular basis;

(2) that each employee will receive, at least annually, a written performance evaluation based upon the duties and responsibilities assigned to that staff member within the job description for that position;

(3) that any professional staff obtain and maintain the skills necessary to meet the individual needs of the consumers to whom the licensee provides services; and

(4) at any time a consumer is employed by a licensee, that the licensee will abide by guidelines for the employment of consumers that may be established by the division. These guidelines shall be available from the division, and each licensee shall be responsible for obtaining these guidelines from the division.

(c) All personnel policies and procedures that a licensee adopts, including any amendments to those policies and procedures, shall be made available for inspection by all members of the staff. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-42 to 30-60-44. Reserved.**

**30-60-45. Administrative records.** Each licensee shall adopt and adhere to written policies and procedures providing for the creation, retention,

and destruction of accurate administrative and business records that shall clearly reflect the business, financial, and administrative operations of the licensee. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-46. Clinical records.** (a) Each licensee shall adopt and adhere to written policies and procedures providing for a written, consolidated, and current clinical record for each consumer to whom the licensee provides any service.

(b) This record shall meet the following criteria:

(1) Be contemporaneously created during the course of services, in accordance with the policies and procedures of the licensee concerning the format, organization, and content of these records;

(2) be stored in a secured location with access limited to staff providing treatment to that consumer, and to other individuals only as specified in the policies and procedures of the licensee; and

(3) be maintained in accordance with policies and procedures of the licensee that provide for the following:

(A) The retention of inactive records;

(B) the destruction of obsolete records;

(C) the duplication of records; and

(D) the release of copies of records. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-47. Confidentiality and release of information.** (a) Each licensee shall adopt and adhere to written policies and procedures that shall ensure the confidentiality of the clinical record, and all portions of that record, and any other information concerning each consumer who has at any time requested or received, or who is currently receiving any services from the licensee. These policies and procedures shall be consistent with any applicable federal or state law, regulation, or rule concerning the confidentiality of that information.

(b) The clinical record, any portion of that record, or any information concerning any consumer who has ever requested or received or who is currently receiving any services from a licensee shall be released only as authorized by law or upon the written authorization of that consumer, or, if applicable, of the parent, legal guardian, or other

appropriate representative of that consumer. This authorization shall contain the following:

(1) The name of the consumer whose clinical record, or any portion of that record, or about whom information is being authorized to be released;

(2) the name and address of, or other information identifying, the person or agency to whom the consumer's clinical record, any portion of that record, or any other information is being authorized to be released;

(3) the name of the licensee or the staff member employed by the licensee being authorized to release the consumer's clinical record, any portion of that record, or any other information;

(4) the reason or purpose for the release of the consumer's clinical record, any portion of that record, or any other information;

(5) (A) A clear indication that the entire clinical record is to be released;

(B) a clear description of the specific portion of the clinical record that is to be released; or

(C) a clear description of what other information is being authorized to be released;

(6) the date, event, or condition upon which the authority to release any information or any portion of the clinical record will expire;

(7) a statement that the consumer authorizing the release of the clinical record, any portion of that record, or any other information reserves the right, to, at any time before this authorization would otherwise expire, revoke the authorization except for any information or record or portion of that record that has already been released, and information concerning how this revocation may be effected;

(8) the date on which the authorization is signed; and

(9) the printed name and the signature of the person authorizing the release, whether the consumer or, if applicable, the parent, legal guardian, or other appropriate representative of the consumer.

(c) Before the release of a consumer's clinical record or any portion of that record, or any other information concerning any consumer who has at any time requested or received any services from a licensee or who is currently receiving any services from a licensee, the staff member making the release shall make a reasonable effort to ensure that the authority or authorization upon which the release is being made is in the proper form and, in the context made, seems appropriate. If the

staff member believes that any question should be raised concerning the release of any information or record, or portion of any record, that staff member shall make a reasonable effort to confirm the propriety of the release. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-48. De-escalation techniques and emergency behavioral interventions.** (a) Each center shall adopt and adhere to written policies and procedures that require the following:

(1) Each staff member, volunteer, and contractor shall utilize only de-escalation techniques or emergency behavioral interventions that the staff member, volunteer, or contractor has been appropriately trained in or is professionally qualified to utilize. Each use of these techniques and interventions shall be consistent with the rights of consumers as listed in K.A.R. 30-60-50.

(2) No practice utilized shall be intended to humiliate, frighten, or physically harm a consumer.

(3) No practice that becomes necessary to implement shall continue longer than necessary to resolve the behavior at issue.

(4) Physical restraint or seclusion shall be used as a method of intervention only when all other methods of de-escalation have failed and only when necessary for the protection of that consumer or others.

(5) Each instance of the utilization of a physical restraint or the use of seclusion shall be documented in the consumer's clinical record required by K.A.R. 30-60-46 and reviewed by supervising staff and the center's risk management program required by K.A.R. 30-60-56.

(6) Each instance in which the utilization of a de-escalation technique or emergency behavioral intervention results in serious injury to the consumer shall be reported to the division.

(b) Each center shall ensure that each affiliated provider with which the center has an affiliation agreement adheres to the center's policies and procedures adopted in compliance with subsection (a) of this regulation. (Authorized by K.S.A. 39-1603(d) and (t), 65-4434(f), and 75-3306b; implementing K.S.A. 39-1603, 39-1604(d), 65-4434(f), 75-3304a, and 75-3307b; effective July 7, 2003.)

**30-60-49. Transportation.** (a) Each li-

censee providing any transportation to consumers shall adopt and adhere to written policies and procedures that require the following:

(1) Before a staff member, a volunteer, or a contractor provides any transportation of a minor consumer, the staff member, volunteer, or contractor shall obtain permission to transport that minor from the minor's parent or legal guardian. If the transportation of a minor is necessary because of a medical or other emergency and permission cannot be obtained, the nature of the emergency and the reason why that permission was unable to be obtained shall be documented in the consumer's clinical record required by K.A.R. 30-60-46.

(2) Each driver of any vehicle used to transport a consumer shall be 18 years of age or older and shall hold a current operator's license for the type of vehicle being used.

(3) Each vehicle owned or leased by the licensee shall be covered by accident and liability insurance. Documentation of the current insurance coverage shall be kept both within the vehicle and in the administrative records maintained by the licensee in accordance with K.A.R. 30-60-45.

(4) Each vehicle owned or leased by the licensee shall be equipped with a fire extinguisher and a first-aid kit, and shall be maintained in a safe operating condition.

(5) No more persons may be transported in a vehicle than the number of safety restraints that the vehicle contains. No more than one person may utilize a single safety restraint at any time.

(6) Only age-appropriate safety restraints may be utilized.

(7) No trailer pulled by another vehicle or truck bed may be utilized to transport any consumer. No motorcycle may be utilized to transport any consumer.

(8) Smoking shall not be permitted at any time a minor consumer is being transported. Smoking shall not be permitted if any consumer being transported objects to that smoking.

(9) The driver of the vehicle shall not smoke, use a cellular telephone, or eat or drink while the vehicle is in motion.

(10) The driver shall require all parts of each passenger's body to remain inside of the vehicle while the vehicle is in motion.

(11) The driver shall require all doors of the vehicle to be locked while the vehicle is in motion.

(12) The driver shall not leave any minor con-

sumer unattended in the vehicle at any time. The driver shall make certain that no consumer is left in the vehicle before vacating the vehicle.

(13) The driver shall transport each consumer directly to the intended destination without any unauthorized stops en route, except in cases of emergency.

(14) The driver shall require other staff from the licensee to accompany the driver on the trip whenever necessary to provide adequate supervision of the consumers being transported either because of the number of consumers being transported or because of the nature of a consumer's illness or disability.

(15) The driver shall not allow any consumer to enter or exit the vehicle from or into a lane of traffic.

(16) If a personal vehicle belonging to any staff member, a volunteer, or a contractor is utilized to transport a consumer, the driver and owner of the vehicle shall be covered by sufficient liability insurance to protect the interests of any consumer that is transported.

(b) Nothing in this regulation shall be construed to require any licensee to provide transportation to any consumer. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)

**30-60-50. Statement of rights; distribution; adherence to.** (a) Each center shall publish and make available at the center, at the principal place of business of each affiliated provider with which the center has an affiliation agreement, and at other appropriate locations a written statement of the rights of consumers.

(b) Each consumer receiving services from any licensee providing services within the center's service area shall be given a copy of this statement during intake or at the consumer's first appointment, and again at least annually thereafter. Staff shall provide oral or other appropriate explanations that may be required to assist the consumer in understanding the consumer's rights. Delivery of this statement and the provision of any necessary explanations to each consumer shall be documented in that consumer's clinical record required by K.A.R. 30-60-46.

(c) This statement of rights shall contain information that lists the following rights, at a minimum:

(1) The right of the consumer to always be



treated with dignity and respect, and not to be subjected to any verbal or physical abuse or exploitation;

(2) the right of the consumer not to be subjected to the use of any type of treatment, technique, intervention, or practice, including the use of any type of restraint or seclusion, performed solely as a means of coercion, discipline, or retaliation, or for the convenience of staff or any volunteer or contractor;

(3) the right of the consumer to receive treatment in the least restrictive, most appropriate manner;

(4) the right of the consumer to an explanation of the potential benefits and any known side effects or other risks associated with all medications that are prescribed for the consumer;

(5) the right of the consumer to an explanation of the potential benefits and any known adverse consequences or risks associated with any type of treatment that is not included in paragraph (c)(4) and that is included in the consumer's treatment plan;

(6) the right of the consumer to be provided with information about other clinically appropriate medications and alternative treatments, even if these medications or treatments are not the recommended choice of that consumer's treating professional;

(7) the right of a consumer voluntarily receiving treatment to refuse any treatments or medications to which that consumer has not consented, in compliance with the consumer's rights;

(8) the right of a consumer involuntarily receiving treatment pursuant to any court order to be informed that there may be consequences to the consumer if the consumer fails or refuses to comply with the provisions of the treatment plan or to take any prescribed medication;

(9) the right of the consumer to refuse to take any experimental medication or to participate in any experimental treatment or research project, and the right not to be forced or subjected to this medication or treatment without the consumer's knowledge and express consent, given in compliance with the consumer's rights, or as consented to by the consumer's guardian when the guardian has the proper authority to consent to this medication or treatment on the consumer's behalf;

(10) the right of the consumer to actively participate in the development of an individualized treatment plan, including the right to request changes in the treatment services being provided

to the consumer, or to request that other staff members be assigned to provide these services to the consumer;

(11) the right of the consumer to receive treatment or other services from a licensee in conjunction with treatment or other services obtained from other licensed mental health professionals or providers who are not affiliated with or employed by that licensee, subject only to any written conditions that the licensee may establish only to ensure coordination of treatment or any services;

(12) the right of the consumer to be accompanied or represented by an individual of consumer's own choice during all contacts with the licensee. This right shall be subject to denial only upon determination by professional staff that the accompaniment or representation would compromise either that consumer's rights of confidentiality or the rights of other individuals, would significantly interfere with that consumer's treatment or that of other individuals, or would be unduly disruptive to the licensee's operations;

(13) the right of the consumer to see and review the clinical record maintained on that consumer, unless the executive director of the licensee has determined that specific portions of the record should not be disclosed. This determination shall be accompanied by a written statement placed within the clinical record required by K.A.R. 30-60-46, explaining why disclosure of that portion of the record at this time would be injurious to the welfare of that consumer or to others closely associated with that consumer;

(14) the right of the consumer to have staff refrain from disclosing to anyone the fact that the consumer has previously received or is currently receiving any type of mental health treatment or services, or from disclosing or delivering to anyone any information or material that the consumer has disclosed or provided to any staff member of the licensee during any process of diagnosis or treatment. This right shall automatically be claimed on behalf of the consumer by the licensee's staff unless that consumer expressly waives the privilege, in writing, or unless staff are required to do so by law or a proper court order;

(15) the right of the consumer to exercise the consumer's rights by substitute means, including the use of advance directives, a living will, a durable power of attorney for health care decisions, or through springing powers provided for within a guardianship; and

(16) the right of the consumer to at any time

make a complaint in accordance with K.A.R. 30-60-51 concerning a violation of any of the rights listed in this regulation or concerning any other matter, and the right to be informed of the procedures and process for making such a complaint.

(d) Each licensee providing any services within the service area of the center shall at all times adhere to each of these consumer rights. (Authorized by K.S.A. 65-4434(f), 39-1603(r), and 75-3307b; implementing K.S.A. 39-1603, 65-4434(f), 75-3304a, and 75-3307b; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-51. Complaints; review; appeals; procedures; records.** (a) Each center shall adopt and adhere to written policies and procedures that allow for any consumer, individual, or agency to make a written complaint about any member of the staff or any aspect of the center's operations, requirements, or services, or those of any affiliated center or other provider with which the center has an affiliation agreement. These policies and procedures shall include the following requirements and provisions, at a minimum:

(1) Notice shall be displayed at appropriate locations stating that any consumer, individual, or agency has the right to make a complaint. This notice shall also describe the procedures by which a complaint can be made.

(2) No particular form shall be required in order to make a complaint, but appropriate forms shall be made available at appropriate locations for use by any consumer, individual, or agency wishing to make a complaint.

(3) Procedures shall exist so that a complaint can be made confidentially if a consumer, individual, or agency so desires.

(4) The staff of the center shall be trained to be alert to, listen for, and identify a complaint of a significant nature that is made either orally or incompletely by a consumer receiving any services from the center, or from any affiliated center or other provider with which the center has an affiliation agreement. The staff shall be required to assist that consumer to write out the complaint if made orally or to more specifically record that complaint for the consumer if the consumer fails or is unable to completely write out the complaint.

(5) The executive director shall review in a timely manner every complaint made, conduct any investigation as appropriate, and take any appropriate actions.

(6) If the complaint is the result of a discontin-

uation or reduction of any service that had been provided to a consumer, the executive director may, at the executive director's discretion, require that the service that was discontinued or reduced be restored to its former level pending the outcome of the executive director's investigation and determination.

(7) If a complaint received by a center concerns any matter involving the staff or any action, decision, policy, or requirement of an affiliated center or other affiliate, the executive director of the center may refer the complaint to the executive director of that affiliated center or other affiliate for that director's response. The response of the executive director of the affiliated center or other affiliate may be included in or attached to the center's response when a response is made or if a response is required to be made to a consumer.

(8) The executive director of the center shall reply, in writing, to every complaint concerning any aspect of either the center's operations, requirements, or services, or those of any affiliated center or other provider with which the center has an affiliation agreement, that is made by a consumer receiving services from the center, any affiliated center, or any other provider with which the center has an affiliation agreement, not later than 30 days following receipt of that complaint. This reply shall state the executive director's findings and determinations with regard to that complaint.

(9) A system shall be established to analyze all complaints made during specified periods of time to determine whether any trend or pattern appears and, if so, to attempt to identify the cause of those complaints or any other issue presented and to deliver this information either to the executive director or to another appropriate party.

(10) Any consumer who is dissatisfied with a determination of the executive director may appeal that determination to the division.

(11) Each appeal of a determination of the executive director shall be made in writing, within 30 days of receipt of that determination. Each appeal shall be addressed to the executive director of the center and shall state specifically the determination that is being appealed and the reasons why the consumer believes that the determination of the executive director is wrong.

(12) Upon receipt of such an appeal, the executive director may contact the consumer who is appealing and offer to meet personally with that

consumer to see if some agreement or other resolution can be reached, or to offer mediation of the dispute to the consumer.

(13) The appeal of the executive director's determination shall proceed as provided for in this regulation. The executive director shall forward to the division the consumer's written appeal and both the original complaint and the executive director's written reply to that complaint when any of the following circumstances occurs:

(A) The executive director does not choose to make any offer for a meeting or for mediation.

(B) The consumer refuses any offer for a meeting or for mediation.

(C) Thirty days have elapsed following receipt of the appeal, and no agreement or resolution has been reached within that time period through the use of any meeting or meetings, or through a process of mediation.

(14) One or more employees of the division shall be assigned by the department to make an investigation and conduct any proceedings necessary to decide the outcome of the appeal. That employee or panel of employees shall give due regard to the rights and interests of both the consumer who is appealing and the center or the affiliated center or other affiliate against which the complaint was made. These procedures shall include the right of the consumer to be represented in the appeal by any individual of that consumer's choice.

(15) If the appeal resulted from a complaint that any service that had been provided to the consumer was discontinued or reduced, the division employee or panel of employees assigned to hear the appeal shall have the authority to require a licensee to restore that service to its former level during the pendency of the appeal.

(16) Following any investigation or proceeding that is determined appropriate, the division employee or panel of employees assigned to hear the appeal shall make a written decision with regard to the issues appealed. This decision shall be sent to the following individuals:

(A) The consumer and the individual that the consumer selected to represent the consumer, if applicable;

(B) the executive director of the center; and

(C) the executive director of the affiliated center or other affiliate, if applicable.

(17) The decision of the division's employee or panel of employees may be appealed to the office of administrative hearings within the Kansas de-

partment of administration in accordance with article 7.

(18) Records of every complaint and appeal made, and of the final determination or decision made with regard to each complaint, shall be centrally maintained for at least five years.

(b) No consumer shall be denied any service or otherwise penalized solely for any of the following reasons:

(1) Having made a complaint;

(2) having refused any offer to meet, to meet again, or to engage in mediation;

(3) failing to continue any process of mediation even though begun;

(4) failing to resolve or settle the complaint; or

(5) making or pursuing an appeal.

(c) Nothing in this regulation shall be construed to limit the right of any person to bring any action against a licensee that is permitted by law. (Authorized by K.S.A. 39-1603(r), 65-4434(f), and 75-3307b; implementing K.S.A. 39-1603, 65-4434(f), 75-3307b, and 75-3304a; effective July 7, 2003.)

#### **30-60-52 to 30-60-54. Reserved.**

**30-60-55. Quality improvement program; records.** (a) Each center shall adopt and adhere to written policies and procedures that provide for a comprehensive quality improvement program designed to continually measure, assess, and improve the quality of the services that are provided by the center, any affiliated center, or any other provider with which the center has an affiliation agreement. These policies and procedures shall require the following:

(1) An ongoing means by which the program measures the degree of consumer satisfaction with the services, from consumers who are currently being or who have recently been provided these services by the center, any affiliated center, or any other provider with which the center has an affiliation agreement;

(2) an ongoing means of furnishing feedback to the staff that provides those services with regard to each consumer's satisfaction or dissatisfaction; and

(3) procedures that ensure that information gathered or generated by the center's risk management program, required by K.A.R. 30-60-56, and the center's utilization management program, required by K.A.R. 30-60-57, is available to and utilized by the center's quality improvement program.

(b) Records that demonstrate the center's compliance with this regulation shall be centrally maintained for at least five years. (Authorized by K.S.A. 65-4434(f), 39-1603(r), and 75-3307b; implementing K.S.A. 39-1603, 75-3307(b), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-56. Risk management program; records.** (a) Each center shall adopt and adhere to written policies and procedures that provide for a comprehensive risk management program designed to review and evaluate clinical and administrative activities for the following purposes:

(1) Identifying and analyzing incidents that present a risk of harm to consumers, staff, and other individuals, including the public at large, or a risk of financial loss to the center or to any affiliated center or other provider with which the center has an affiliation agreement; and

(2) determining actions that might reduce the risks specified in paragraph (a)(1).

(b) Incidents that the risk management program specified in subsection (a) shall review shall include the following, at a minimum:

(1) Any suicide or homicide, attempted suicide or homicide, or other unexpected death involving a consumer who is currently receiving or has recently received any services from the center, the affiliated center, or any other provider with which the center has an affiliation agreement;

(2) any act or series of acts resulting in significant destruction of property belonging to the center, or to the affiliated center or other provider with which the center has an affiliation agreement, committed by any consumer who is currently receiving or has recently received any services from the center or the affiliated center or other affiliate;

(3) any act or omission that falls or might fall below the applicable standard of care or professional obligation; and

(4) any allegation of abuse, neglect, or exploitation of a consumer who is currently receiving or has recently received any services from the center, the affiliated center, or any other provider with which the center has an affiliation agreement, committed by a member of the staff of the center, any contractor, the affiliated center, or other affiliate.

(c) These policies and procedures shall include the following requirements:

(1) Staff members shall be afforded the oppor-

tunity to confidentially report any incident that a staff member believes is appropriate for review by the risk management program.

(2) Each action that the center, affiliated center, or any other provider with which the center has an affiliation agreement takes in response to any incident that comes to the attention of the risk management program shall conform to all statutory requirements for the reporting of suspected incidents of either child abuse, neglect, or exploitation, or the abuse, neglect, or exploitation of an adult.

(d) Records demonstrating the center's compliance with this regulation shall be centrally maintained for at least five years. (Authorized by K.S.A. 39-1603(r) and 75-3307b; implementing K.S.A. 39-1603(r), 75-3307b, and 75-3304a; effective July 7, 2003.)

**30-60-57. Utilization review program; records.** (a) Each center shall adopt and adhere to written policies and procedures that provide for a comprehensive utilization review program designed to facilitate the delivery of high-quality, cost-effective, appropriate services by the center and by each affiliated provider with which the center has an affiliation agreement.

(b) The policies and procedures specified in subsection (a) shall include the following:

(1) A means to ensure monitoring of the usage of the services of the center and of each affiliated provider with which the center has an affiliation agreement;

(2) a means to determine whether inappropriate or unnecessary services are being provided to any consumer; and

(3) a means to determine whether appropriate or necessary services have not been provided to any consumer.

(c) Records demonstrating the center's compliance with this regulation shall be centrally maintained for at least five years. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)

**30-60-58 to 30-60-59. Reserved.**

**30-60-60.** (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991; revoked July 7, 2003.)

**30-60-61.** (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603,



39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991; revoked July 7, 2003.)

**30-60-62. Basic service delivery standards; service components.** (a) Each licensee shall provide all services in a manner consistent with the following basic service delivery standards. Each service provided by a licensee shall include the following components:

(1) An initial assessment, which shall meet the following criteria:

(A) Be performed by adequately trained and professionally qualified staff; and

(B) be completed and documented within 14 days of a consumer's initial intake to record the following:

(i) All of the presenting problems or requests made by that consumer;

(ii) all pertinent history that can be gathered;

(iii) the consumer's present mental status;

(iv) a provisional diagnosis, as applicable;

(v) any strengths or preferences of the consumer that are disclosed or are discernable; and

(vi) the primary intervention provided or disposition made, or both, including a preliminary individualized treatment plan;

(2) a comprehensive, individualized treatment plan, which shall meet the following criteria:

(A) Be centralized into a single integrated and consolidated document;

(B) be developed beginning with the initial assessment and completed, subject to necessary and appropriate revisions, within 30 days thereafter;

(C) be developed with the participation of the consumer and, if appropriate, one or more members of the family of that consumer or other individuals designated by that consumer, evidenced by the signature of that consumer or by other documentation indicating this participation and stating the reason for the absence of the consumer's signature;

(D) contain identified goals, objectives, strengths, and preferences of the consumer, based upon the problems presented, the consumer's requests, the consumer's diagnosis, and the assessed needs of that consumer, each as identified during the initial assessment and subsequently during treatment;

(E) whenever multiple services are being provided, or whenever services are being provided by multiple providers, require that those services be coordinated by a single individual not necessarily employed by the licensee, in a manner that en-

sures the integration of the services being provided; and

(F) be regularly reviewed and revised as appropriate, with the participation of the consumer and, when appropriate, one or more members of the family of that consumer or other individuals designated by that consumer. Reviews and revisions shall occur at periodic intervals of not more than 90 days and shall be updated with appropriate notations in the clinical record;

(3) a written, chronological clinical record, as required by K.A.R. 30-60-46, which shall document the consumer's progress toward meeting the identified goals and objectives contained within that consumer's individualized treatment plan, including documentation of each treatment, other service or intervention provided to that consumer, and appropriate notations of dates and times;

(4) regular consultations with the consumer and, when appropriate, with members of the family of that consumer or other individuals designated by that consumer, for the following purposes:

(A) Ensuring that the licensee's treatment staff have complete, accurate, and current information concerning the circumstances and needs of that consumer or of the members of the consumer's family; obtaining any necessary consent for the release of information to the staff; and confirming and following up on previous consultations or referrals;

(B) identifying other treatment providers, agencies, or other individuals who are providing any treatment or supportive services to that consumer or to any members of the consumer's family;

(C) arranging for the appropriate sharing of information from that consumer's clinical record with other treatment providers, agencies, or other individuals, who either provide or may be able to provide any treatment or supportive services to that consumer or to members of the consumer's family;

(D) involving other appropriate treatment providers, agencies, or individuals, who either provide or could provide other treatment or supportive services to that consumer or to one or more members of the consumer's family, in a process that assures the appropriate, integrated, and efficient delivery of treatment and services; and

(E) reviewing with the consumer the progress of the consumer in treatment and making appropriate modifications to that consumer's individu-

alized treatment plan, including any appropriate modifications that are requested by that consumer or by one or more members of the consumer's family;

(5) regular consultations with other treatment providers, agencies, or other individuals providing any treatment or supportive services to a consumer or to one or more members of the consumer's family, for the purposes of ensuring coordination, continuity, and appropriate transitions in that consumer's treatment or supportive services; and

(6) a discharge or termination plan, which shall meet the following criteria:

(A) Be developed in a manner consistent with the consumer's individualized treatment plan;

(B) if possible, be developed with the participation of that consumer and, if appropriate, with the participation of one or more members of the consumer's family or with other individuals designated by that consumer;

(C) include a plan for appropriate postdischarge or posttermination of treatment contact by staff with that consumer and, if appropriate, with one or more members of the consumer's family or other individuals designated by that consumer;

(D) include referrals to other treatment providers and supportive services when appropriate; and

(E) result in a final written summary notation, which shall be included in the consumer's clinical record required by K.A.R. 30-60-46.

(b) Compliance with these basic service delivery standards shall be appropriately documented in the consumer's clinical record required by K.A.R. 30-60-46. (Authorized by K.S.A. 39-1603(r), 65-4434(f), and 75-3307b; implementing K.S.A. 39-1603, 65-4434(f), 75-3307b, and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-63. Timeliness of response; requirements; documentation when unable to comply; referral to quality improvement program.** (a) Each center shall respond to every contact or request for services by first determining, in a manner that is consistent with applicable clinical practices, whether or not that initial request constitutes an emergency.

(b) If the initial request is determined to be an emergency, all services that are required by K.A.R. 30-60-64 to be provided by a center shall be provided immediately as necessary to resolve

the emergency. After the emergency has been resolved, if the consumer is not detained for inpatient care and treatment, that consumer shall be scheduled for a follow-up appointment and provided any necessary and appropriate services consistent with the requirements of this regulation.

(c) If the initial request is determined to be an urgent matter or a routine matter, the consumer shall be scheduled for an appointment with the appropriate staff within a timely period after that initial contact.

(d) After a consumer's first appointment, the center shall begin providing any necessary and appropriate services to that consumer within a timely period.

(e) If a center is unable to comply with the requirements of this regulation, the appropriate staff member shall document in the consumer's clinical record, as required by K.A.R. 30-60-46, the reason or reasons why the center was unable to comply with the requirements of this regulation. The staff member shall report the same information to the center's quality improvement program required by K.A.R. 30-60-55. (Authorized by K.S.A. 39-1603(r), 65-4434(f), and 75-3307b; implementing K.S.A. 39-1603, 65-4434(f), 75-3307b, and 75-3304a; effective July 7, 2003.)

**30-60-64. Required basic community support services.** (a) Each center shall provide as appropriate, through the center, a contractor, or any affiliated center or other provider with which the center has an affiliation agreement, each of the following basic community support services:

(1) Orientation services, including a means by which any person can discover, or become oriented to the center or its contractors or affiliated providers, through information concerning the following:

(A) What services are offered by the center, its contractors, its affiliated centers, or any other affiliates, and how to access those services, in a manner consistent with the requirements of K.A.R. 30-60-15;

(B) what the requirements or expectations are for each service offered, whether to qualify for or to continue to receive those services;

(C) what fees are charged for any service, and under what circumstances those fees may be adjusted, as required by K.A.R. 30-60-17; and

(D) what rights a consumer has, in a manner

consistent with the requirements of K.A.R. 30-60-50;

(2) public education, including community education programs concerning the following:

(A) What mental illness or severe emotional disturbance is;

(B) what the symptoms of mental illness or severe emotional disturbance are;

(C) what treatments are available;

(D) what the community can do to assist and support persons with a mental illness or a severe emotional disturbance; and

(E) what individuals can do to dispel the myths about mental illness and severe emotional disturbance;

(3) emergency treatment and first response services, which shall be provided on a 24-hour-per-day, seven-day-per-week basis and shall include the following:

(A) Crisis responsiveness, including, when appropriate, staff going out of the office and to the individual for personal intervention, for any person found within the service area of the center who is thought to be experiencing a crisis or other emergency;

(B) referral to psychiatric and other community services, when appropriate, for any person found within the service area of the center;

(C) emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services;

(D) evaluation of any person found within the service area of the center to determine the need for either inpatient or involuntary psychiatric care and treatment. This evaluation shall meet the following criteria:

(i) Be completed as soon as possible, but in any case not later than 24 hours after the initial request for that evaluation is made by any individual or agency. The evaluation shall be completed sooner if necessary to provide the certificate required by K.S.A. 59-2957(c)(1) and amendments thereto; and

(ii) be conducted in a place and manner that address the needs of that person;

(E) screening for admission to a state psychiatric hospital, when applicable and required by K.A.R. 30-61-10; and

(F) follow-up with any consumer seen for or provided with any emergency service and not detained for inpatient care and treatment, to deter-

mine the need for any further services or referral to any services;

(4) basic outpatient treatment services, including the following:

(A) Evaluation and diagnosis;

(B) individual, group, and family therapy;

(C) medication management, including a means by which a consumer can receive the following under the direction and supervision of a licensed physician:

(i) A prescription for any medication required to treat the consumer's mental illness or severe emotional disturbance;

(ii) assistance with obtaining any medication prescribed for the treatment of the consumer's mental illness or severe emotional disturbance;

(iii) education concerning the effects, benefits, and proper usage and storage of any medication prescribed for the treatment of the consumer's mental illness or severe emotional disturbance;

(iv) assistance with the administration of, or with monitoring the administration of, any medication prescribed for the treatment of the consumer's mental illness or severe emotional disturbance; and

(v) any physiological testing or other evaluation necessary to monitor that consumer for adverse reactions to, or for other health-related issues that might arise in conjunction with, the taking of any medication prescribed for the treatment of the consumer's mental illness or severe emotional disturbance; and

(D) referral to other community treatment providers and services, when appropriate;

(5) basic case management services for adults, which shall be provided to any adult consumer who has a severe or persistent mental illness and who is determined to be in need of case management services. Case management services shall be provided either by a single individual acting as the case manager or by a team of individuals jointly acting as the case manager. If a team is jointly acting as the case manager, an individual from that team shall be assigned the responsibility for overseeing the provision of case management services to each consumer. Each individual case manager and each member of a team of case managers shall be sufficiently qualified by education and experience, and shall have completed, or shall have completed within six months, a case management training program that has been approved by the division and is specifically focused upon adults. Each case manager shall have the responsibility to

provide, through a mutually acceptable process involving the consumer, the following:

(A) Engagement services and activities, including the following:

(i) Engaging the consumer in a purposeful, supportive, and helping relationship;

(ii) eliciting the consumer's choices concerning basic needs, including determining where the consumer desires to reside, what supports the consumer desires to rely upon, what productive activities the consumer desires to engage in, and what leisure activities the consumer desires to participate in; and

(iii) understanding the consumer's personal history and either satisfaction or dissatisfaction with services and treatments, including medications, that have been provided to or prescribed for that consumer in the past;

(B) strengths assessment services and activities, including the following:

(i) Identifying and assessing the consumer's wants and needs, the consumer's aspirations for the future, the resources that are or might be available to that consumer, the sources of motivation available to the consumer, and the strengths and capabilities the consumer possesses;

(ii) identifying and assessing what the consumer's preferences are with regard to having designated members of the consumer's family involved in the consumer's treatment, or with regard to having other designated individuals involved in the consumer's treatment, and depending upon what those preferences are, determining how best to involve those designated family members or other individuals in the consumer's assessment, treatment, and rehabilitation;

(iii) identifying and researching what educational and vocational, financial, and social resources are or might be available to the consumer and might facilitate that consumer's recovery; and

(iv) identifying, researching, and understanding the cultural factors that might have affected or that might affect the consumer's experience with receiving treatment and other services, the role that family and other natural supports play in the life of that consumer, the effects that these factors might have on the treatment process, and the ways in which these factors might be used to support the consumer's recovery;

(C) goal-planning services and activities, including the following:

(i) Helping the consumer to identify, organize, and prioritize the consumer's personal goals and

objectives with regard to independent living, education and training, employment, and community involvement;

(ii) assisting and supporting the consumer in choosing and pursuing activities consistent with achieving those goals and objectives at a pace consistent with that consumer's capabilities, resources, and motivation;

(iii) teaching the consumer goal-setting and problem-solving skills, and living, social, and self-management skills;

(iv) identifying critical stressors that negatively affect the consumer's mental status and those interventions, coping strategies, and supportive resources that have been successful or helpful in addressing or relieving those stressors in the past; and

(v) developing relapse-prevention strategies, including wrap-around plans and advance directives, which the consumer may choose to utilize;

(D) resource acquisition services and activities, including the following:

(i) Assisting the consumer to access housing, transportation, education, job training, employment, public assistance, and recreational services available in the community;

(ii) assisting the consumer in finding and utilizing services provided by peer-companion programs, mutual support groups, and self-help organizations; and

(iii) ensuring that the consumer is knowledgeable of, and assisting the consumer in accessing, necessary and available medical and dental services and treatment;

(E) emergency services coordination during periods of crisis;

(F) advocacy services and activities, including the following:

(i) Acting as a liaison between the consumer and that consumer's other service providers;

(ii) coordinating the treatment and supportive efforts of all the consumer's service providers, family members, and peers;

(iii) advocating for the consumer, as appropriate, in developing goals and objectives within the consumer's individualized treatment plan during the course of that consumer's treatment, and in acquiring the resources necessary for achieving those goals and objectives;

(iv) identifying factors that place the consumer at high risk for suicide, violence, substance abuse, victimization, or infection with serious medical disorders, including HIV, and assisting that con-



sumer to develop strategies to eliminate or mitigate these risks; and

(v) providing ongoing education to the consumer, to members of that consumer's family, and to other individuals involved with that consumer about mental illness, treatment, medication and its side effects, rehabilitation, empowerment, and supportive resources;

(6) basic community-based support services for children, adolescents, and their families, which shall include consultative and advocative services and activities designed to assist professionals, service agencies, governmental and educational entities, and other individuals in understanding, planning for, developing, and comprehensively meeting the special needs of children and adolescents who either have a severe emotional disability or disorder or are mentally ill, and are therefore considered to be at risk of hospitalization or other out-of-home placement, and meeting the special needs of their families; and

(7) basic case management services for children, adolescents, and their families, which shall be provided to any child or adolescent consumer who either has a severe emotional disability or disorder or has been diagnosed as mentally ill and who is determined to be in need of case management services, and to the immediate family with whom that child or adolescent consumer resides or with whom it is intended that the child or adolescent consumer will reside. Case management services shall be provided either by a single individual acting as the case manager or by a team of individuals acting jointly as the case manager. If a team is jointly acting as the case manager, an individual from that team shall be assigned the responsibility for overseeing the provision of case management services to each child or adolescent and the family. Each individual case manager and each member of a team of case managers shall be sufficiently qualified by education and experience, and shall have completed, or shall have completed within six months, a case management training program that has been approved by the division and is specifically focused upon children, adolescents, and their families. Each case manager shall have responsibility to provide the following:

(A) Engagement services and activities, including the following:

(i) Engaging the child or adolescent and members of the child's or adolescent's family in a purposeful, supportive, and helping relationship;

(ii) eliciting the family's choices concerning what supports the family desires to utilize; and

(iii) understanding both the child's or adolescent's and the family's experiences and either satisfaction or dissatisfaction with services and treatments, including medications, that have been provided to or prescribed for that child or adolescent in the past;

(B) strengths assessment services and activities, including the following:

(i) Identifying and assessing the child's or adolescent's and the family's wants and needs, their goals, the resources that are or might be available to them, and the strengths and capabilities that both the child or adolescent and the family possess;

(ii) identifying and researching what educational, financial, and social resources are or might be available to the child or adolescent, or to the family, and that might facilitate that child's or adolescent's or the family's treatment; and

(iii) identifying, researching, and understanding the cultural factors that might have affected or that might affect the child's or adolescent's or the family's experience with receiving treatment and other services, the role that natural supports play in the life of that child or adolescent or in the functioning of the family, the effects that these factors might have on the treatment process, and the ways in which these factors might be used to support the child or adolescent, or the family;

(C) goal-planning services and activities, including the following:

(i) Helping the child or adolescent and the child's or adolescent's family to identify and prioritize specific goals and objectives based upon needs identified during the strengths assessment;

(ii) assisting and supporting the child or adolescent and the child's or adolescent's family in choosing and accessing the services and supports necessary for achieving those goals and objectives and for increasing that family's community integration;

(iii) identifying critical stressors that negatively affect the child's or adolescent's or the family's ability to function, and developing interventions and coping strategies to address or relieve those stressors; and

(iv) developing crisis strategies that the child or adolescent or a member of the child's or adolescent's family can utilize to control symptomatic behavior in order to avoid crisis situations that present a risk of harm to either the child or ado-

lescent or to others, or that result in an out-of-home placement of that child or adolescent;

(D) resource acquisition services and activities, including the following:

(i) Assisting the child or adolescent and the child's or adolescent's family to obtain needed benefits and services that are available in the community;

(ii) assisting the child or adolescent and the child's or adolescent's family in finding and utilizing services provided by peer-companion programs and groups, and other support organizations; and

(iii) ensuring that the family is knowledgeable of, and assisting the family in accessing, necessary and available medical and dental services and treatment;

(E) emergency services coordination during periods of crisis;

(F) transitional services and activities, which shall meet the following criteria:

(i) Commence in early adolescence in order to assist the adolescent to move into adulthood and to transition to services intended for adults; and

(ii) include the utilization of a wrap-around approach to services involving the appropriate persons and agencies necessary to coordinate and collaborate with the educational, employment, living, and supportive services necessary to ensure community integration and tenure; and

(G) advocacy services and activities, including the following:

(i) Acting as a liaison between the child or adolescent, or the child's or adolescent's family, and that child's, adolescent's, or family's other service providers;

(ii) coordinating the treatment and supportive efforts of all the child's or adolescent's or the family's service providers, including educational, child welfare, and juvenile justice agencies;

(iii) advocating for the child or adolescent or for the child's or adolescent's family, as appropriate, in developing goals and objectives within that child's or adolescent's individualized treatment plan during the course of that child's or adolescent's treatment and in acquiring the resources necessary for achieving those goals and objectives;

(iv) identifying factors that place the child or adolescent at risk for suicide, violence, substance abuse, victimization, or infection with serious medical disorders, including HIV, and assisting both the child or adolescent and the members of

the child's or adolescent's family to develop strategies to eliminate or mitigate those risks; and

(v) providing ongoing education to the child or adolescent, to the members of the child's or adolescent's family, and to other persons involved with that child or adolescent about severe emotional disturbances and behavior disorders, treatment, medication and its side effects, rehabilitation, empowerment, and supportive resources.

(b) Each center shall adopt and adhere to written policies and procedures, which shall include the following requirements:

(1) The services required to be provided by this regulation shall be provided by staff who are supervised by professionals who are sufficiently qualified by education and experience.

(2) The caseloads of staff providing these services shall be monitored and managed in a manner that ensures the quality of the services provided.

(3) Supervision of case managers shall be provided by supervisors who are sufficiently qualified by education and experience and who have completed a supervisory training program approved by the division.

(4) No consumer shall be denied access to any of these services solely on the basis of any previous unsuccessful intervention or experience.

(5) Continuity shall be maintained, whenever possible, in any relationship that might be established between a consumer and a staff member that provides any services to that consumer.

(6) Appropriate staff shall be encouraged to provide the majority of their services to consumers in settings outside of the offices of that center or those of any affiliated center or other provider with which the center has an affiliation agreement.

(c) Each center shall ensure that each affiliated center or other provider with which the center has an affiliation agreement adheres to the center's policies and procedures adopted in compliance with subsection (b) of this regulation.

(d) If a center elects to provide any of these basic community support services through any contractor, affiliated center, or other provider with which the center has an affiliation agreement, the center shall regularly monitor the services provided by that contractor or affiliated center or other affiliate to ensure the quality of the services that are provided and compliance with the requirements of this regulation. (Authorized by K.S.A. 39-1603(r), 65-4434(f), and 75-3307b;

implementing K.S.A. 39-1603, 65-4434(f), 75-3304a, and 75-3307b; effective July 7, 2003.)

**30-60-65 to 30-60-69. Reserved.**

**30-60-70. Optional services.** The services specified in K.A.R. 30-60-71 through K.A.R. 30-60-76 shall be deemed optional services that a licensee may choose to offer directly or through a contractor. If a licensee elects to provide any or all of these services, the licensee, or its contractor, shall comply with the provisions of the applicable regulations. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-71. Alcohol and substance abuse services.** If a licensee provides, directly or through a contractor, specialized alcohol or substance abuse services, these services shall meet the following conditions: (a) Be separately licensed or certified as required by the department;

(b) be provided by appropriately trained or professionally qualified staff; and

(c) be administered in accordance with written policies and procedures adopted by the licensee. (Authorized by K.S.A. 75-3307b; and implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-72. Acute care services.** If a center provides, directly or through a contractor, services consisting of inpatient care and treatment that is more intensive than outpatient treatment, in a facility or unit that is separately licensed by this department as a psychiatric hospital or by the Kansas department of health and environment as a general hospital, but that is operated by the licensee, these services shall meet the following conditions: (a) Be provided in the least restrictive manner appropriate, following generally accepted clinical standards of practice;

(b) provide both medical and nursing services as each consumer's care requires;

(c) be provided by appropriately trained or professionally qualified staff; and

(d) be administered in accordance with written policies and procedures adopted by the licensee. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-73. Partial or day hospitalization services.** If a licensee provides, directly or through a contractor, partial or day hospitalization services, these services shall meet the following conditions: (a) Be provided in compliance with the requirements of the department's medicaid regulations;

(b) be provided by appropriately trained or professionally qualified staff; and

(c) be administered in accordance with written policies and procedures adopted by the licensee. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-74. Residential treatment services.** If a licensee provides, directly or through a contractor, residential treatment services at a facility other than in a consumer's own home, these services shall meet the following conditions: (a) Be separately inspected or licensed as required by the Kansas department of health and environment, or by this division or any other division within this department, if applicable;

(b) be provided in accordance with an individualized plan developed for each consumer provided with any residential treatment services, which shall be developed with the participation of that consumer and, when appropriate, members of the immediate family of that consumer or other individuals designated by that consumer. This plan shall be based on an assessment of the level of supervision and support necessary for that consumer to be able to function in the least restrictive setting possible;

(c) be provided by appropriately trained or professionally qualified staff; and

(d) be administered in accordance with written policies and procedures adopted by the licensee. These policies and procedures shall require that the facility be maintained in a manner that meets any applicable state or local fire or safety code. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-60-75.** (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991; revoked July 7, 2003.)

**30-60-76. Research programs.** If a li-

censee conducts research programs utilizing human subjects, directly through research being conducted by the staff of the licensee or of a contractor, these programs shall meet the following conditions: (a) Be strictly conducted under written policies and procedures adopted by the licensee and developed specifically for each research project;

(b) require review of any proposed project by a specifically established committee of appropriately selected professionals before the initiation of the research;

(c) be conducted only on subjects who are capable of and who have given written, informed consent to be the subject of a specific research project; and

(d) strictly adhere to any applicable professional standards regarding the conducting of research, as well as all applicable federal and state laws and regulations. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

#### **Article 61.—PARTICIPATING COMMUNITY MENTAL HEALTH CENTERS**

**30-61-1. Scope.** The regulations in this article shall apply to each community mental health center licensed by the secretary in accordance with article 60 that desires to enter into a contract with the secretary pursuant to the “mental health reform act,” K.S.A. 39-1601 et seq., and amendments thereto, for the purposes of being a participating community mental health center. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-61-2. Definitions.** Words and phrases used in this article but not defined in this regulation shall have the same meanings as they are defined to have in the “care and treatment act for mentally ill persons,” K.S.A. 59-2945 et seq., and amendments thereto, in the “mental health reform act,” K.S.A. 39-1601 et seq., and amendments thereto, or in K.A.R. 30-60-2. (a) “Community mental health center” and “center” mean a community mental health center that is organized pursuant to K.S.A. 19-4001 et seq., and amendments thereto, or K.S.A. 65-211 et seq., and amendments thereto, and that is licensed by

the secretary in accordance with article 60. These terms shall not include any community mental health center licensed by the secretary in accordance with article 60 and meeting the exception specified in K.S.A. 75-3307b(b) and amendments thereto.

(b) “Participating community mental health center” means a community mental health center, as defined in this regulation, that has entered into a contract with the secretary in accordance with this article.

(c) (1) “Target population” means any of the following categories of consumers:

(A) Adults with a severe and persistent mental illness;

(B) children or adolescents with a severe emotional disturbance; or

(C) other individuals at risk of requiring institutional care because of a mental illness.

(2) Each of the categories of consumers listed in this subsection may be further defined within the contract provided for in K.A.R. 30-61-5. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

#### **30-61-3 and 30-61-4. Reserved.**

**30-61-5. Annual contracts; application; plan for compliance; term.** (a) Each community mental health center desiring to become the participating community mental health center for its service area shall apply to the secretary for a contract on an annual basis at the time and in the manner that shall be announced by the secretary.

(b) Each center that desires to become a participating community mental health center may be required by the secretary to submit to the division, in addition to the center’s application for a contract, a plan detailing how the center will come into and stay in compliance with the applicable requirements of this article if the center has not before been in compliance. This plan shall be reviewed by the division. A recommendation shall be made by the division to the secretary concerning whether a contract should be awarded or denied.

(c) If the parties agree to a contract, the term during which the center is considered to be a participating mental health center shall be specified in the contract. During the term in which the center is considered to be a participating community mental health center, the center shall provide the



additional services required to be provided by this article or by the contract.

(d) A center shall have no obligation to be a participating community mental health center, or to be in compliance with the requirements of this article, beyond the term specified in the contract if the center does not subsequently contract with the secretary to be a participating community mental health center. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-61-6. Preference for licensed service area center; secretary's right to contract with another licensed center.** (a) Preference shall be given to the community mental health center in each service area to enter into a contract with the secretary to become the participating community mental health center for that area.

(b) The secretary shall have the right to contract with another center to provide the services of a participating community mental health center to that service area if any of the following conditions is met:

(1) The center fails to timely enter into a contract to become a participating community mental health center.

(2) The center is unwilling to enter into a contract to provide all of the required services of a participating community mental health center.

(3) The secretary determines that the center is unable or has failed in the past to adequately provide all of the required services of a participating community mental health center. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-61-7 to 30-61-9. Reserved.**

**30-61-10. Screening and gatekeeping services.** (a) Each participating community mental health center shall provide, when necessary or when requested and necessary, to any person found within the service area of the center, screening services to determine whether either of the following applies:

(1) The person can be evaluated or treated by community services.

(2) The person needs to be admitted to the designated state psychiatric hospital for evaluation or treatment, or both.

(b) This screening and gatekeeping service shall meet the following criteria:

(1) Be performed by a qualified mental health professional;

(2) be completed by utilizing the screening assessment instrument designated by the division for this purpose; and

(3) if the screening results in a determination that the person needs to be admitted to a state psychiatric hospital, whether on a voluntary or involuntary basis, be evidenced by a completed statement upon the form designated by the division for this purpose.

(c) The center shall arrange for any protective custody necessary to complete the screening.

(d) The center shall offer to provide, shall provide, or shall refer to and coordinate with another appropriate provider, including providing any follow-up that might be necessary, any appropriate and necessary services that are required by this article to be provided by a participating community mental health center or that are required by article 60 to be provided by a center, to any person meeting the following criteria:

(1) Is determined by the qualified mental health professional acting on behalf of that center not to be in need of admission to a state psychiatric hospital; and

(2) is in need of treatment or could benefit from any of the services required by this article to be provided by a participating community mental health center or required by article 60 to be provided by a center. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective Oct. 28, 1991; amended July 7, 2003.)

**30-61-11. Liaison services.** (a) Each participating community mental health center shall designate staff who shall perform the following:

(1) Regularly visit at the hospital with every person admitted to a state psychiatric hospital from the service area of the center, whether on a voluntary or involuntary basis;

(2) participate in the discharge planning of each person admitted to a state psychiatric hospital from the service area of the center in order to facilitate the return of that person to the community;

(3) be empowered by the center to commit the center to specified services upon the discharge and return to the community of any person ad-

mitted to a state psychiatric hospital from the service area of the center; and

(4) coordinate the treatment provided at the state psychiatric hospital with the treatment provided by either the center or any affiliated provider with which the center has an affiliation agreement.

(b) The names and professional qualifications of liaison staff shall be communicated by the executive director of the center to the superintendent of the state psychiatric hospital to which the liaison staff is assigned.

(c) The liaison staff shall follow all rules of the state psychiatric hospital while on the campus of the hospital. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)

**30-61-12 to 30-61-14. Reserved.**

**30-61-15. Enhanced community support services.** (a) Each participating community mental health center shall provide directly, or through a contractor, an affiliated center, or any other provider with which the center has an affiliation agreement, enhanced community support services in extension of the services required to be provided by K.A.R. 30-60-64, including the following:

(1) Outreach services designed to achieve the following:

(A) Identify and locate persons in the target population, particularly persons who do not often seek mental health services in traditional ways;

(B) encourage these persons to utilize the services of the center, its affiliated centers, or other affiliates; and

(C) offer special assistance to these persons, as required, in order to enable them to utilize the services of the center, its affiliated centers, or other affiliates;

(2) public education about the enhanced services that are available at the center or through its contractors, affiliated centers, or other affiliates;

(3) liaison services with any nursing facilities for mental health that are located in the center's service area or to which a person from the center's service area has been admitted, designed to facilitate the discharge of persons residing in those nursing facilities who could live in the community with the assistance and support provided by the services available through the center, its affiliated centers, or other affiliates;

(4) any services necessary to provide any treatment required to fulfill a court order for outpatient treatment that is issued by the district court of any county within the service area of the center; and

(5) attendant care services, designed as an extension of the center's basic outpatient treatment services, basic case management services for adults, basic community-based support services for children, adolescents, and their families, and basic case management services for children, adolescents and their families, required by K.A.R. 30-60-64, tailored specifically to accomplish the following:

(A) To enhance the independence of consumers in the target population;

(B) to reduce the risks for the need to be admitted to a state psychiatric hospital that are known to be associated with consumers in the target population;

(C) to facilitate the discharge of consumers in the target population who have been admitted to any state psychiatric hospital; and

(D) to otherwise assist consumers in the target population to be able to live in the community.

(b) Each center shall adopt and adhere to written policies and procedures that shall require all of the following:

(1) The services required to be provided by this regulation shall be provided by staff who are supervised by professionals who are sufficiently qualified by education and experience.

(2) The caseloads of staff members providing these services shall be monitored and managed to ensure the quality of the services provided.

(3) No consumer shall be denied access to any of these services solely on the basis of any previous unsuccessful intervention or experience.

(4) Continuity shall be maintained, whenever possible, in any relationship that might be established between a consumer and staff member that provides any services to that consumer.

(5) Appropriate staff shall be encouraged to provide the majority of their services to consumers in settings outside of the offices of the center.

(c) If a participating community mental health center elects to provide any of these enhanced community support services through any contractor, affiliated center, or other provider with which the center has an affiliation agreement, the center shall regularly monitor that contractor, center, or provider to ensure compliance with the requirements of this regulation and the quality of the

services that are provided. (Authorized by K.S.A. 39-1603(r), 65-4434(f), and 75-3307b; implementing K.S.A. 39-1603, 65-4434(f), 75-3304a, and 75-3307b; effective Oct. 28, 1991; amended July 7, 2003.)

**30-61-16.** (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991; revoked July 7, 2003.)

#### Article 62.—RESERVED

#### Article 63.—DEVELOPMENTAL DISABILITIES—LICENSING PROVIDERS OF COMMUNITY SERVICES

**30-63-1. Definitions.** (a) Words and phrases used in this article shall have the same meanings as set forth in K.S.A. 39-1803, and amendments thereto. In addition, the following terms shall have the meaning ascribed to them in this regulation.

(1) “Agent” means any individual utilized by a provider to carry out any activity done by that provider, whether being paid or serving as a volunteer.

(2) “Commissioner” means the commissioner of mental health and developmental disabilities.

(3) “Commission” means the division of mental health and developmental disabilities within the department of social and rehabilitation services.

(4) “Department” means the department of social and rehabilitation services.

(5) “Person” means an individual with a developmental disability.

(6) “Provider” means a community services provider or any other entity required to be licensed pursuant to this article.

(7) “Services” means community services.

(8) “Support network” means the one or more individuals selected by a person or by the person and the person’s guardian, if one has been appointed, to provide assistance and guidance to that person in understanding issues, making plans for the future, or making complex decisions.

(b) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

#### **30-63-10. License required; exceptions.**

(a) Any individual, group, association, corporation, local government department, or local quasi-government agency providing services to persons 18 years of age or older in need of services greater than those provided in a boarding care home as defined in K.S.A. 39-923(a)(8), and amendments thereto, shall be licensed in accordance with the provisions of this article, except when those services are provided in or by any of the following:

(1) In a medical care facility, as defined and required to be licensed in K.S.A. 65-425, et seq.;

(2) in a nursing facility, nursing facility for mental health, intermediate care facility for the mentally retarded, assisted living facility, or residential health care facility, or in a home plus setting, as defined and required to be licensed in K.S.A. 39-923, et seq.;

(3) by a home health agency, as defined and provided for the licensing of in K.S.A. 65-5101, et seq.; or

(4) in a manner so that the services constitute in-home services, funded under the home- and community-based services/mental retardation waiver, provided in compliance with all of the following conditions:

(A) The services are directed and controlled by an adult receiving services, the parent or parents of a minor child receiving services, or the guardian of an adult receiving services.

(B) The person directing and controlling the services selects, trains, manages, and dismisses the person or persons providing the services, and coordinates payment.

(C) The person directing and controlling the services owns, rents, or leases the whole or a portion of the home in which services are provided.

(D) If any person providing services also lives in the home in which services are provided, there is a written agreement specifying that the person receiving services will not be required to move from the home if there is any change in who provides services, and that any person chosen to provide services will be allowed full and reasonable access to the home in order to provide services.

(E) The person receiving services does not receive services in a home otherwise requiring a license pursuant to these regulations.

(F) Any person providing services is at least 16 years of age, or at least 18 years of age if a sibling of the person receiving services, unless an exception to this requirement has been granted by the commission, based upon the needs of the person receiving services.

(G) Any person providing services receives at least 15 hours of prescribed training, or the person directing and controlling the services has provided written certification to the community developmental disability organization (CDDO) that sufficient training to meet the person's needs has been provided.

(H) The person directing and controlling the services has chosen case management from the CDDO or an agency affiliated with the CDDO. That case management may be limited, at the choice of the person directing and controlling the services, to reviewing the services on a regular basis to ensure the person's needs are met, annual reevaluation of continued eligibility for funding, and development of the person's plan of care.

(I) The person directing and controlling the services cooperates with the CDDO's quality assurance committee and allows review of the services as deemed necessary by the committee to ensure that the person's needs are met. In addition, the person directing and controlling the services cooperates with the commission and allows monitoring of the person's services to ensure that the case manager and the CDDO's quality assurance committee have adequately reviewed and determined that the person's needs are met.

(J) The person directing and controlling the services agrees to both of the following:

(i) If it is determined by the CDDO or the commission that the person receiving services is or may be at risk of imminent harm to the person's health, safety, or welfare, the person directing and controlling the services shall correct the situation promptly.

(ii) If the situation is not so corrected, after notice and an opportunity to appeal, funding for the services shall not continue.

(b) Any license issued pursuant to this article shall be valid only for the provider named on the license. Any substantial change of control or ownership of a corporation previously licensed pursuant to this article shall void that license and shall require a reapplication for licensure.

(c) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-63-11. One type of license; display.**

(a) The only type of license issued by the secretary

pursuant to this article shall be a license to operate as a provider of community services.

(b) A license issued pursuant to this article shall be prepared by the commission. The holder of the license shall prominently display the license in the holder's principal place of business.

(c) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-63-12. Licensing procedure; provisional license; duration of license.** (a) Any provider required to be licensed shall submit an application for a license to the commissioner, in the manner and format prescribed by the commission.

(b) Upon receipt of any application, the commission shall make findings as to whether the applicant is in compliance with the requirements of this article.

(c) The provider shall be notified in writing if the commission finds that the applicant is not in compliance with the requirements of this article.

(d) The commissioner may issue a provisional license to begin or continue the operations of a provider. A provisional license shall be contingent upon the provider developing and implementing an acceptable course of corrective action intended to bring the provider into continuing compliance with the requirements of this article.

(1) Findings made by the commission with regard to the implementation of a course of corrective action shall be given to the provider in writing.

(2) Failure of a provider to implement an acceptable course of corrective action may be grounds for denial of a license whether or not a provisional license has been issued.

(e) Based upon findings made by the commission regarding compliance or the implementation of an acceptable course of corrective action, the commissioner may determine whether to issue or deny the license applied for. The applicant shall be notified in writing of any decision to deny a license. The notice shall clearly state the reasons for denial. The applicant may appeal this denial to the administrative appeals section pursuant to article seven of these regulations.

(f) Except for a provisional license, any license issued pursuant to this article shall remain in effect for one year from the date of issuance, unless:

- (1) revoked for cause;
- (2) voided; or



(3) voluntarily surrendered by the provider.

(g) Each provisional license shall specify the length of time for which it shall be valid. Successive provisional licenses may be issued by the commissioner.

(h) In order to renew a license, any applicant shall reapply for a license in accordance with this regulation.

(i) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-63-13. Compliance reviews; mediation; enforcement actions; emergency orders.** (a) At any time deemed necessary by the commissioner, a licensed provider may be reviewed by the commission to ensure continuing compliance with the requirements of this article.

(b) If a finding indicates that the licensed provider is not in compliance, the provider shall be given by the commissioner a written copy of the finding setting out each specific deficiency and a notice of the provider's right to seek mediation of any dispute regarding the finding.

(c) If the provider disagrees with any finding made by the commission, the provider may request mediation, in writing, within 14 days of receipt of the finding. An independent entity shall be selected by the commissioner and the provider to serve as the mediator, unless the parties are not able to agree upon a mediator, in which case an independent mediator shall be designated by the secretary. The mediator shall assist the parties in attempting to come to an agreement on the following:

(1) The nature and extent of any noncompliance;

(2) any course of corrective actions necessary to bring the provider into compliance; and

(3) a time limit within which the provider shall have to come into compliance.

(d) (1) Written notice may be issued by the commissioner to the provider of a determination of noncompliance under any of the following circumstances.

(A) The provider does not request mediation.

(B) Mediation does not resolve the issues.

(C) The commission finds that the provider has not complied with the requirements of this article by the deadline established in a mediated agreement or a deadline that has been extended by the commissioner for good cause.

(2) If the commissioner issues written notice to the provider of a determination of noncompliance in accordance with paragraph (d)(1), a written plan of correction from the provider shall be required by the commissioner, to be submitted within 14 days of receipt of the notice.

(3) If the commissioner determines that the provider has failed to satisfactorily comply with the plan of correction within 30 days of the date of the plan, or within a deadline that has been extended by the commissioner for good cause, any or all of the following enforcement actions may be imposed:

(A) Civil penalties in an amount not to exceed \$125.00 per day for each violation from the date specified by the commissioner within the notice until the provider comes into compliance. The date specified by the commissioner may be any date from or after 45 days following the date of the commissioner's notice requiring a plan of correction;

(B) an order that the provider shall cease providing specified services and shall make all necessary arrangements to have any person or persons then receiving services transferred to another provider. The order may include provisions requiring the provider to continue the provision of those or other services until the transfer can be accomplished. The order shall remain in effect until the provider comes into compliance;

(C) suspension or revocation of the provider's license as provided for in K.A.R. 30-63-14.

(e) A provider may appeal any enforcement action taken to the administrative appeals section pursuant to article seven of these regulations.

(f) If the commission additionally finds that the provider's noncompliance creates a situation of imminent danger to the health, safety, or welfare of any person or persons, an emergency order may be issued by the commissioner, making any provisions that the commissioner deems necessary for the immediate protection of the health, safety, or welfare of the person or persons. Written notice of any emergency order shall be given to the provider and shall specify the following:

(1) The actions that the provider shall take;

(2) the reason the commissioner has determined an emergency order is needed; and

(3) notice that the provider will be given an emergency hearing regarding the emergency order by the administrative appeals section pursuant to article seven of these regulations if the provider

makes a written request for a hearing within 15 days after receiving the order.

(g) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-63-14. Revocation of a license; suspension.** (a) Any license issued pursuant to this article may be suspended or revoked before the expiration date for failure of the provider to comply with the requirements of this article.

(b) A provider's license may be suspended during the revocation proceedings only upon a determination by the commissioner that the continued operation of the provider during the revocation proceedings would constitute an imminent danger to the health, safety or welfare of any person or persons who would be receiving services from the provider during the revocation proceedings. This determination shall be made in writing and clearly state the reasons for it.

(c) Before revocation of a provider's license, a written notice of the intent to revoke shall be sent to the provider by registered mail, along with a copy of the commissioner's determination to suspend the license during the revocation proceedings, if applicable. The notice shall:

- (1) specify the date the license shall be revoked if an appeal is not timely taken;
- (2) clearly state the reasons for the revocation of the license;
- (3) instruct the provider to immediately cease providing services if the commissioner has determined to suspend the license during the revocation proceedings; and

(4) advise the provider that the revocation may be appealed to the administrative appeals section pursuant to article seven of these regulations, and that an appeal shall stay the revocation, but shall not stay any suspension of the license during the pendency of the appeal, except as may be provided for in any order issued after an emergency hearing held as a result of a request made under K.A.R. 30-63-13(f)(3).

(d) If at any time during the pendency of an appeal the commissioner finds that the provider now complies with all of the requirements of this article, and that it is in the best interests of the public that the revocation be withdrawn, the commissioner shall notify all parties to the revocation proceedings that the revocation action has been

withdrawn and the appeal proceedings shall be terminated.

(e) If, after notice to the provider of the commissioner's intent to revoke, the provider does not timely appeal, the license shall be revoked by the commission effective on the date stated within the notice.

(f) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-63-20. Mandated requirements.** (a) In order to be eligible to be licensed as a provider, each applicant shall demonstrate that the applicant either complies with or can comply with all applicable requirements of this article and all applicable requirements of article 64.

(b) For good cause shown by an applicant, or by any person being served or proposed to be served by that applicant, one or more of the specific requirements of this article may be waived by the commissioner, and some other requirement or requirements that may be proposed by the applicant or person may be substituted by the commissioner, if the waiver or substitution would neither jeopardize the health, safety, or well-being of any person or persons served or proposed to be served by the applicant, nor substantially deviate from meeting the intent or purpose of the requirement or requirements being waived.

(c) Attainment of national accreditation by an applicant from an organization that evaluates and accredits providers of mental retardation or developmental disabilities services, or the recommendation of a local CDDO's quality assurance committee, shall be considered by the commissioner in determining compliance by the applicant with any one or more of the requirements of this article. (Authorized by K.S.A. 39-1810 and K.S.A. 2005 Supp. 75-3307b; implementing K.S.A. 39-1806; effective July 1, 1996; amended Oct. 1, 1998; amended Dec. 8, 2006.)

**30-63-21. Person-centered support planning; implementation.** (a) The provider shall prepare a written person-centered support plan for each person served that shall meet these requirements:

- (1) Be developed only after consultation with the following:
  - (A) The person;
  - (B) the person's legal guardian, if one has been appointed; and

(C) other individuals from the person's support network as the person or the person's guardian chooses;

(2) contain a description of the person's preferred lifestyle, including describing the following:

(A) In what type of setting the person wants to live;

(B) with whom the person wants to live;

(C) what work or other valued activity the person wants to do;

(D) with whom the person wants to socialize; and

(E) in what social, leisure, religious, or other activities the person wants to participate;

(3) list and describe the necessary activities, training, materials, equipment, assistive technology, and services that are needed to assist the person to achieve the person's preferred lifestyle;

(4) describe how opportunities of choice will be provided, including specifying means for the following:

(A) Permitting the person to indicate the person's preferences among options presented to the person, by whatever communication methods that person may possess, including a description of the effective communication methods utilized by the person;

(B) providing the necessary support and training to allow the person to be able to indicate the person's preferences, including a description of any training and support needed to fully participate in the planning process and other choice making; and

(C) assisting the person or the person's guardian to understand the negative consequences of choices the provider knows the person might make and that may involve risk to that person;

(5) describe when it is necessary to do so, to the person and the person's support network, how the preferred lifestyle might be limited because of imminent significant danger to the person's health, safety, or welfare based on an assessment of the following:

(A) The person's history of decision-making, including any previous experience or practice the person has in exercising autonomy, and the person's ability to learn from the natural negative consequences of poor decision-making;

(B) the possible long- and short-term consequences that might result to the person if the person makes a poor decision;

(C) the possible long- and short-term effects

that might result to the person if the provider limits or prohibits the person from making a choice; and

(D) the safeguards available to protect the person's safety and rights in each context of choices;

(6) prioritize and structure the delivery of services toward the goal of achieving the person's preferred lifestyle;

(7) contribute to the continuous movement of the person towards the achievement of the person's preferred lifestyle. In evaluating this outcome, the provider may include assessments made by professionals and shall perform either of the following:

(A) Include consideration of the expressed opinions of the person, the person's legal guardian, if one has been appointed, and other individuals from the person's support network; or

(B) account for the following:

(i) The financial limitations of the person and the provider;

(ii) the supports and training needed, offered, and accepted by the person; and

(iii) matters identified in paragraph (a)(5). Next best options may be considered as responsive if the person cannot specifically have what the person prefers due to limitations identified by this methodology; and

(8) be approved, in writing, by the person or the person's guardian, if one has been appointed. Requirements for approval from or consultation with the person's guardian shall be considered to have been complied with if the provider documents that it has taken reasonable measures to obtain this approval or consultation and that the person's guardian has failed to respond.

(b) Whenever two or more providers provide services to the same person, the providers shall work together to prepare a single person-centered support plan. Each provider shall be responsible for the preparation and implementation of any portion of the plan relating to its services. The person, the guardian if one has been appointed, a member of the person's support network, or a provider shall take the lead coordination role in preparation of the plan, and a designation of that person or entity shall be noted in the plan.

(c) The provider shall regularly review and revise the plan, by following the same procedures as set out above, whenever necessary to reflect any of the following:

(1) Changes in the person's preferred lifestyle;

(2) achievement of goals or skills outlined within the plan; or

(3) any determination made according to the methodology provided for in paragraph (a)(7) above that any service being provided is unresponsive.

(d) The provider shall deliver services to the person only in accordance with the person's person-centered support plan.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-63-22. Individual rights and responsibilities.** (a) Each provider shall at all times encourage and assist each person served to understand and exercise the person's individual rights and to assume the responsibilities that accompany these rights.

(b) Each person served shall be guaranteed the same rights afforded to individuals without disabilities. These rights may be limited only by provisions of law or court order, including guardianship, conservatorship, power of attorney or other judicial determination. These rights shall include the following:

(1) Being free from physical or psychological abuse or neglect, and from financial exploitation;

(2) having control over the person's own financial resources;

(3) being able to receive, purchase, have, and use the person's personal property;

(4) actively and meaningfully making decisions affecting the person's life;

(5) having privacy;

(6) being able to associate and communicate publicly or privately with any person or group of people of the person's choice;

(7) being able to practice the religion or faith of the person's choice;

(8) being free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment, for the convenience of a provider or agent, in conflict with a physician's orders or as a substitute for treatment, except when physical restraint is in furtherance of the health and safety of the person;

(9) not being required to work without compensation, except when the person is living and being provided services outside of the home of a member of the person's family, and then only for

the purposes of the upkeep of the person's own living space and of common living areas and grounds that the person shares with others;

(10) being treated with dignity and respect;

(11) receiving due process; and

(12) having access to the person's own records, including information about how the person's funding is accessed and utilized and what services were billed for on the person's behalf.

(c) Each provider shall train its agents regarding the rights specified in subsection (b). In addition, each provider shall offer training at least annually regarding these rights and effective ways to exercise them to each person served, to the guardian if one has been appointed, and to the person's parent and other individuals from each person's support network. (Authorized by K.S.A. 39-1810; implementing K.S.A. 39-1802 and K.S.A. 39-1806; effective July 1, 1996; amended Oct 1, 1998; amended Dec. 8, 2006.)

**30-63-23. Medications; restrictive interventions; behavioral management committee.** (a) A provider shall take proactive and remedial actions to ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness. These actions shall be taken before the provider initiates the use of any medication or other restrictive intervention to manage behavior, unless the needs of the person served clearly dictate otherwise and the provider documents that need. Otherwise, these actions shall be taken promptly following the initiation of, or any change in, the use of any medication or other restrictive intervention to manage behavior or to treat diagnosed mental illness.

(b) These proactive and remedial actions shall include all the following:

(1) Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following, in consultation with the person, the person's guardian, and the person's support network:

(A) All other potentially effective, less restrictive alternatives have been tried and shown ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective;

(B) positive behavior programming, environmental modifications and accommodations, and



effective services from the provider are present in the person's life;

(C) voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications; and

(D) medications are administered only as prescribed, and no "PRN" (provided as needed) medications are utilized without both the express consent of the person or the person's guardian if one has been appointed, and per usage approval from the prescribing physician or another health care professional designated by the person or the person's guardian if one has been appointed;

(2) management, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following:

(A)(i) When restrictive intervention or medication is being used to manage specific behaviors, those behaviors are documented as to the frequency and objective severity of occurrence;

(ii) the provider periodically reviews and reports to the person, the person's guardian if one has been appointed, the person's support network, and the physician prescribing any medication to manage behavior, the frequency and objective severity of the specific behaviors, and the effectiveness of the restrictive intervention or medication and any side effects experienced from any medication used to manage specific behaviors, in conjunction with safeguard measures; and

(iii) the provider recommends to the person, the person's guardian if one has been appointed, the person's support network, and the physician prescribing any medication to manage behavior, reducing the use of the restrictive intervention or medication being used to manage specific behaviors, when appropriate, based upon the documented effectiveness of those efforts in conjunction with safeguard measures; or

(B) when medication is used to treat specifically diagnosed mental illness, the medication has been prescribed and is being managed by a psychiatrist who is periodically provided information regarding the effectiveness of and any side effects experienced from the medication. The prescription and management may be by a physician, rather than a psychiatrist, only when requested and agreed to by the person or the person's guardian if one has been appointed, and when based upon the documented need of the person; and

(3) review by a behavior management committee established by the provider, which shall meet these criteria:

(A) Be made up of a selected number of persons served, guardians of persons served, family members of persons served, interested citizens, and providers, at least  $\frac{1}{3}$  of whom shall be otherwise unassociated with the provider; and

(B) periodically review the use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness, to ensure that the provisions of this regulation are met and to report to the provider each instance in which the committee determines that any provision of this regulation has not been met. The provider shall immediately correct any instance of noncompliance reported by the behavior management committee.

(c) Requirements for consent from or consultation with the person's guardian shall be considered to have been complied with if the provider documents that it has taken reasonable measures to obtain the consent or consultation and that the person's guardian has failed to respond.

(d) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective Aug. 23, 1996; amended Oct. 1, 1998.)

**30-63-24. Individual health.** (a) A provider shall assist each person served, as necessary, in obtaining the medical and dental services to which the person has access and that may be required to meet the person's specific health care needs, including the following:

(1) Scheduling and receiving preventative examinations and physicals;

(2) practicing for obtaining emergency services;

(3) developing individualized procedures for the administration of medications and other treatments, including training for self-medication or administration; and

(4) obtaining necessary supports, including adaptive equipment, and speech, hearing, physical, or occupational therapies, as appropriate.

(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.

(c) A provider shall train staff who shall be responsible to implement the service provider's

written policies and procedures for carrying out medication administration, including the following:

- (1) Self-administration by any person;
- (2) medication checks and reviews;
- (3) emergency medical procedures; and
- (4) any other health care task.

(d) Whenever two or more providers provide services to the same person, the providers shall work together to meet the health care needs of the person. The person, the guardian if one has been appointed, a member of the person's support network, or a provider may take the lead coordination role, and a designation of that person or entity shall be noted in the person-centered support plan.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-63-25. Nutrition assistance.** (a) Except when a provider is providing services to a person living in the home of a member of that person's family, the provider shall assist each person served in obtaining daily access to a well-balanced, nutritious diet consistent with the provisions of K.A.R. 30-63-21 regarding opportunities of choice. If a person being served lives in the home of a family member, a provider shall assist that person similarly with any meals provided outside of that home setting.

(b) A provider that serves a person meals shall serve each modified or special diet meal in a form consistent with both the person's needs and desires and any medical directions with regard thereto.

(c) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-63-26. Staffing; abilities; staff health.**

(a) A provider shall provide professional and direct service staff in numbers sufficient to meet the support and service needs of each person being served.

(b) Each employee shall be able to perform the employee's job duties before working without oversight by another trained staff person.

(c) Each employee shall consistently satisfactorily perform the employee's assigned job duties

throughout the term of the employee's employment.

(d) Staff who have been certified by a recognized training agency to give CPR and first aid shall be available in sufficient numbers whenever persons being provided services are present.

(e) All staff or consultants representing themselves as professionals subject to national, state, or local licensing, certification or accreditation standards shall be in compliance and maintain compliance with those standards.

(f) Each staff member shall monitor the member's personal health and avoid circumstances in which the member risks exposing a person to whom the member is providing services to contagious disease or other health endangerment.

(g) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-63-27. Emergency preparedness.** (a)

Each agent of each provider shall be:

(1) trained in general fire, safety and emergency procedures;

(2) trained and able to effectively and efficiently evacuate any building within which the agent is providing services, including knowing:

(A) alternative exit routes;

(B) methods of accounting for persons who might be present in the building at any time; and

(C) a designated meeting place outside the building to which all persons will go in the event of an evacuation;

(3) trained and able to effectively and efficiently seek shelter in any building within which the agent is providing services, in the event of a tornado or other dangerous storm; and

(4) trained and able to respond effectively and efficiently to other emergency conditions, including power outages or flooding.

(b) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-63-28. Abuse; neglect; exploitation.**

(a) Whenever any agent of a provider suspects that abuse, neglect, or exploitation is or has taken place, that agent shall immediately take appropriate action to ensure that any specifically involved person or persons and all others are protected while an investigation is conducted.

(b) Each agent shall exercise any authority that

the agent has for the purpose of the prevention of abuse, neglect, or exploitation of each person served.

(c) A provider shall regularly conduct training and take other steps to ensure that any agent, person, parent, guardian, and any other individual from each person's support network is advised about how to contact the appropriate state agency charged with providing adult protective services whenever abuse, neglect, or exploitation is suspected or witnessed.

(d) The provider shall immediately report any incident of suspected abuse, neglect, or exploitation of which the provider has become aware to the appropriate state agency charged with providing adult protective services. Any agent shall immediately report any incident of suspected abuse, neglect, or exploitation, in either manner:

- (1) Directly to the appropriate state agency; or
- (2) in accordance with the provider's written policy for reporting an incident. A provider shall inform each agent that any report of an incident of suspected abuse, neglect, or exploitation may be made directly or anonymously to the appropriate state agency, shall ensure that each agent has ready access to the phone number for making any report, and shall take no steps to interfere with an agent making any report directly or anonymously.

(e) Each agent shall fully cooperate with any state agency conducting an investigation resulting from a report of abuse, neglect, or exploitation.

(f) A provider shall not employ any individual who is known by a provider to have had a conviction for or a prior employment history of abuse, neglect, or exploitation of children or vulnerable adults.

(g) A provider shall adhere to all laws, regulations, and procedures related to the reporting of, protecting from, and correcting the cause of abuse, neglect, or exploitation.

(h) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-63-29. Records.** (a) A provider shall maintain records for each person served. These records shall include the following:

- (1) any application or agreement for services;
- (2) any financial agreement made between the provider and the person;

(3) any incident or accident reports;

(4) a health profile, which shall be reviewed for accuracy by a licensed medical practitioner at least every two years, and shall include the following:

(A) notations regarding the person's health status;

(B) any medications the person takes; and

(C) any other special medical or health considerations which might exist for that person;

(5) basic assessment and service information system (BASIS) documents and other evaluation materials;

(6) the person's person-centered support plan;

(7) the plan of care for recipients of the home and community based services for persons who are mentally retarded or developmentally disabled program (HCBS/MR);

(8) releases of information, authorizations for publication, and consents for emergency and other medical treatment; as applicable; and

(9) a discharge summary, if applicable.

(b) A provider shall maintain each record confidentially and shall not release any record except:

(1) as authorized in writing by the person or the person's legal guardian, if one has been appointed;

(2) as otherwise authorized by law; or

(3) as necessary to comply with the requirements of this article.

(c) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-63-30. Physical facilities.** (a) A provider shall maintain each site in which services are provided to any person and that is owned, leased, or made available by contract to be operated by a provider, any employee or board member of a provider, or any entity owned or controlled by a provider, a provider's employee or a provider's board member, so that the site shall meet these requirements:

(1) Have appropriate fire and safety equipment that is in good repair and is kept on site and readily accessible;

(2) not have any combustible or flammable materials kept in an unsafe location;

(3) be kept clean and well maintained;

(4) be kept safe and secure;

(5) have furniture and equipment in good repair and working order;

(6) be capable of maintaining a comfortable temperature and adequate ventilation;

(7) have adequate lighting;

(8) be free of insect and rodent infestation;

(9) have main routes of travel that are kept free of obstacles and stored materials;

(10) have appropriate assistive devices and any necessary structural modifications so that the facility meets the needs of persons with physical disabilities;

(11) be sufficiently sized to meet the living space needs of the person or persons residing there as well as the additional space needs of staff working within the premises, specifically including appropriate space or spaces for the following:

(A) Meal preparation;

(B) dining;

(C) sleeping;

(D) bathing, toileting, and hand washing;

(E) recreation and day living; and

(F) storage of personal items; and

(12) meet the needs of each person being served, consistent with the preferred lifestyle of the person or persons; and

(13) be in compliance with all applicable fire and life safety, health, sanitation, and occupancy codes.

(b)(1) A provider shall monitor each facility in which services are provided, but that is not included in subsection (a) above, to determine whether or not the facility meets these requirements:

(A) Is maintained in compliance with all applicable fire and life safety, health, sanitation, and occupancy codes; and

(B) is of sufficient size and is equipped and stocked to permit the provider to provide the necessary services, activities, and training required by the person-centered support plan of any person being served at that site.

(2) If the provider is made aware of circumstances that create a violation of any fire and life safety, health, sanitation, or occupancy code, or that place a person's health, safety, or welfare in imminent danger, or if the provider determines that the facility fails to meet any required standard as specified by any person's person-centered support plan, the provider shall perform the following:

(A) Notify the person's support network of the nature of the deficiency; and

(B) implement any necessary corrective action by appropriate means, including any appropriate

revisions to the person's person-centered support plan.

(c) Each facility intended to accommodate eight or more persons or in which eight or more persons are living shall be licensed by the Kansas department of health and environment as a lodging establishment pursuant to K.S.A. 36-501, et seq., and amendments thereto.

(d) A provider shall maintain each facility used for job training or production work in compliance with any applicable occupational health or safety code or regulation, including any provisions applicable to any equipment or machinery located or used within that facility.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-63-31. Registration with the community developmental disability organizations (CDDOs).** (a) Anytime a provider does not have an affiliation agreement in force with the CDDO for that service area, the provider shall:

(1) register with the CDDO, listing the types of services that the provider provides; and

(2) periodically give notice to the CDDO of the provider's current availability to offer services.

(b) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-63-32. Case management.** (a) Each community services provider providing case management services shall perform the following:

(1) Develop and implement policies and procedures concerning the provision of case management services that are consistent with the requirements of this regulation;

(2) provide those services in a manner meeting all applicable requirements of this article; and

(3) ensure that all case management services are provided by case managers who meet the following requirements:

(A) No case manager shall provide any other direct service except case management services to any person receiving any other type of direct service from the same agency that employs the case manager;

(B) no case manager shall be supervised by anyone directly responsible for the provision of any



other type of direct service provided to any person or responsible for supervision of those services;

(C) each case manager shall comply with the division's "rules of conduct for case managers serving people with developmental disabilities," as adopted on October 25, 2003, and hereby adopted by reference;

(D) each case manager shall maintain documentation that shows that within 90 calendar days of either the case manager's initial employment or following an announcement by the division posted upon the division's web site of a revision of the division's required assessment, whichever comes later, the case manager has completed and passed the required assessment that has been established by the division and that has been included in the division's case management-related training; and

(E) each case manager shall have the following documented qualifications:

(i) A minimum of six months of full-time experience in the field of human services; and

(ii) either a bachelor's degree or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of six months of full-time experience for each missing semester of college.

(b) Case management services shall assist the person and the person's support network to identify, select, obtain, coordinate, and use both paid services and natural supports that are available to that person to enhance the person's independence, integration, and productivity consistent with the person's capabilities and preferences as outlined in the person's person-centered support plan. Case management services shall include the following:

(1) Assessment, including an ongoing process for the identification of the person's needs, the determination of a person's preferred lifestyle, and the resources that are available to the person, through both formal and informal evaluation methods;

(2) (A) Support planning, with the participation of the person and the person's support network, including the development or assistance in the development, updating, and reviewing of the person's person-centered support plan and any related service or support plan, building upon assessment information to assist the person in meeting the person's needs and achieving the person's preferred lifestyle; and

(B) providing assistance to the person in being knowledgeable about the types and availability of

community services and support options, in receiving information regarding the rights of persons served pursuant to the developmental disabilities reform act and implementing regulations, the content of which shall be approved by the commission, and in obtaining the community services and supports of the person's choice;

(3) support coordination, including the following:

(A) Arranging for and securing supports outlined in the person's person-centered support plan; and

(B) developing and accessing natural supports and generic community support systems, including pursuing means for gaining access to needed services and entitlements, and seeking modification of service systems when necessary to increase the accessibility to those systems by the person;

(4) monitoring and follow-up, including ongoing activities that are necessary to ensure that the person-centered support plan and related supports and services are effectively implemented and adequately addressing the needs of the person; and

(5) assisting transition and portability, including the planning of and arranging for services to follow the person when the person moves between any of the following:

(A) From school to the adult world;

(B) from an institution to community alternatives;

(C) from one kind of service setting to another kind of service setting;

(D) from one provider to another provider; or

(E) from one service area to another service area. (Authorized by K.S.A. 39-1810; implementing K.S.A. 39-1805 and 39-1806; effective May 30, 2008.)

#### **ARTICLE 64.—DEVELOPMENTAL DISABILITIES—COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATIONS (CDDOs)**

**30-64-1. Definitions.** (a) Words and phrases used in this article shall have the same meanings as those set forth in K.S.A. 39-1803 or as defined in article 63. In addition, the following terms shall have the meaning ascribed to them in this regulation:

(1) "home county" means, as determined by the CDDO in accordance with the following listed order of priority:

(A) the county of residence of a family member of the person with a development disability;

(B) the county of residence of the person's guardian; or

(C) the county in which the person is living; and

(2) "service area" means the counties from which a CDDO receives funding pursuant to K.S.A. 19-4001, et seq.

(b) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-64-10. Currently established and recognized community mental retardation centers now recognized as community developmental disability organizations (CDDOs).**

(a) Each community mental retardation center organized pursuant to the provisions of K.S.A. 19-4001, et seq., currently established and operating as of the effective date of this regulation, shall be recognized as a CDDO. The CDDO shall have the same service area that the community mental retardation center was previously recognized for.

(b) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 19-4001 and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-64-11. Establishment of new community developmental disability organizations (CDDOs).** (a) Except in compliance with this article, a new CDDO shall not be established if the proposed service area is already being served by one or more existing CDDOs.

(b) Except in compliance with this article, an existing CDDO shall not alter its existing service area to include an area already being served by one or more existing CDDOs.

(c) Along with the proposal to establish a new CDDO, anyone proposing the establishment of a new CDDO shall submit an application for a license for the CDDO to operate as a provider of community services in compliance with in article 63, unless the organization, corporation or agency proposed as the new CDDO is already licensed, or unless the proposed CDDO does not intend to provide community services itself.

(d) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 19-4001 and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-64-12. Application for approval of a**

**proposal to establish a new community developmental disability organization or to realign the service area of one or more existing CDDOs; requirements.** (a) Anyone proposing the establishment of a new CDDO, or the realignment of the service area of any existing CDDO, shall apply for approval of the proposal to the commissioner in writing. The application shall include the following:

(1) A description of the service area or areas to be created;

(2) a copy of the establishing resolution or resolutions adopted pursuant to K.S.A. 19-4001, and amendments thereto, by the affected board or boards of county commissioners;

(3) a statement of the problems thought to exist with the current structure of community services for persons with developmental disabilities within that service area or areas and how the new or realigned CDDO or CDDOs will address those problems;

(4) a description of what specific services the new or realigned CDDO or CDDOs will provide;

(5) a plan for how any other services needs of the proposed service area will be met;

(6) a description of the planned structure of governance, organization, staffing, and fiscal management procedures that will be used by the new or realigned CDDO;

(7) a long-range financial plan detailing how the new or realigned CDDO proposes to finance itself during the initial five-year period;

(8) a statement of the anticipated fiscal and service impacts that this new or realigned CDDO will have on all other affected service areas of the state;

(9) an endorsement of the proposal by the governing board or boards and chief executive officer or officers of any affected existing CDDOs, or an explanation of why an endorsement has not or cannot be obtained; and

(10) written comments received from the public and a summary of public comments made at a public hearing held for the purpose of receiving comments concerning the proposal. The commission shall have been consulted in advance of this public hearing, and approval of the process to be used for obtaining public comments shall have been given by the commission. Any process for obtaining public comments shall contain a method for notifying all existing CDDOs and licensed community service providers that operate in the

service area or areas to be affected by the proposal.

(b) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 19-4001 and K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-64-13. Approval or disapproval of a proposal to establish a new community developmental disability organization or to re-align the service area of one or more existing CDDOs.** (a) Before the approval or disapproval of a proposal to establish a new CDDO, or to re-align the service area of one or more existing CDDOs, the materials submitted as required by K.A.R. 30-64-12 shall be reviewed by the commission. Additional comments from any of the following may be received or sought out as the commission deems appropriate:

- (1) consumer and advocacy organizations or representatives;
- (2) other interested individuals and agencies; and
- (3) licensed providers in and near the proposed new or re-aligned service area or areas.

(b) The proposal shall be approved or disapproved by the commissioner and the applicant shall be notified of that determination in writing. The notice shall clearly state the reasons why the proposal is disapproved.

(c) An applicant may appeal any decision to disapprove a proposal to establish a new CDDO or to re-align the service area of one or more existing CDDOs to the administrative appeals section pursuant to the provisions of article seven of these regulations.

(d) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 19-4001 and K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-64-20. Contracting community developmental disability organizations; requirements; enforcement actions.** (a) Each CDDO established according to this article desiring to contract with the secretary pursuant to the provisions of the developmental disabilities reform act, K.S.A. 39-1801 et seq., and amendments thereto, shall comply with the provisions of this article.

(b) Any CDDO having entered into a contract with the secretary, but failing to maintain compliance with the provisions of this article or with the

provisions of the contract, may be subject to one or more of the following enforcement actions:

(1) The requirement of a corrective action plan, approved by the commission, with specific corrective or improvement activities identified and implemented, measurable outcomes, and implementation timelines;

(2) the requirement of a peer review process, approved by the commission, with specific review and improvement activities identified and implemented, measurable outcomes, and implementation timelines;

(3) suspension of part or all of the payments provided for in the contract until the violation is corrected;

(4) civil penalties in an amount not to exceed \$125.00 per day for each violation from a specified date forward until the CDDO complies; or

(5) cancellation of the contract.

The contract may specifically provide for any or all of the penalties specified in this subsection. (Authorized by and implementing K.S.A. 39-1804, 39-1805, 39-1807, and 39-1810; effective July 1, 1996; amended Feb. 1, 2002.)

**30-64-21. Procedures applicable to the service area; development by the CDDO.** (a) The governing board of each CDDO desiring to contract with the secretary shall develop written procedures, subject to approval by the commissioner, which shall specify how the requirements of this article will be met within that service area by the CDDO, and if applicable, by affiliating providers. These procedures shall include provisions which allow any affiliating provider which employs 20 or more direct care employees to contract with the department for direct payment in lieu of receiving payments from the CDDO.

(b) At least 30 days before final adoption, the governing board shall present these procedures to the service area's council of community members organized pursuant to K.A.R. 30-64-22(a)(3), who may provide written comment upon them to the board. The board shall include any comments by the council with the procedures when the procedures are submitted to the commissioner.

(c)(1)(A) At least 30 days before final adoption, the governing board shall present these procedures to interested parties and the public at a public hearing held for the purposes of receiving comments upon these procedures; or

(B) other means may be used to solicit and receive comments about these procedures from in-

interested parties and the public at least 30 days before final adoption.

(2) The commission shall have been consulted in advance of this public hearing or the board's decision to use any other means to obtain public comments, and the commission shall have given approval of the process to be used. The board shall summarize any comments received and include them with the procedures when the procedures are submitted to the commissioner.

(d) The governing board shall obtain approval of these procedures by the commissioner before the CDDO may be awarded a contract by the secretary. The CDDO shall not make any changes to these procedures after their approval except in compliance with the procedures set forth in subsections (b) and (c) above. The CDDO shall obtain approval of these changes by the commissioner, in writing, before those changes may become effective.

(e) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-64-22. Implementation responsibilities of CDDOs.** Each contracting CDDO shall perform the following:

(a) Implement the approved service area procedures specified in K.A.R. 30-64-21;

(b) collect and report to the secretary, in a manner specified by the commission, all information requested by the commission, including the following:

(1) Information required by the basic assessment and services information system (BASIS);

(2) copies of the plans of care detailing home- and community-based services to be provided to persons served by that program;

(3) copies of independent financial audits obtained by the CDDO, as well as any management letters generated as a result of the audits; and

(4) any other information or records the CDDO has that the commission needs in order to monitor how services are provided in the CDDO's service area;

(c) organize a council of community members as specified in K.A.R. 30-64-31;

(d) organize a local committee on quality assurance as specified in K.A.R. 30-64-27;

(e) ensure that all services are provided in a manner that meets these requirements:

(1) Provides to all persons equal access to services, including to persons currently residing in any

ICF/MR or institution but referred to the CDDO for possible services;

(2) provides that each person receiving or applying for community services, and that person's guardian if one has been appointed, receives information at least annually, communicated in a format appropriate for the person to understand, regarding the following:

(A) The types of community services available in the person's service area and information concerning the providers of those services; and

(B) the rights of persons served pursuant to the developmental disabilities reform act and implementing regulations, the content of which shall be approved by the commission;

(3) enables a person or the person's guardian, if one has been appointed, to choose the person's community service provider; and

(4) promotes the efficient delivery of services within the service area; and

(f) ensure that each community service provider entering into an affiliating agreement with the CDDO and operating within the CDDO's service area abides by the procedures applicable to that service area as established by the CDDO according to K.A.R. 30-64-21. In meeting this requirement, the CDDO may establish a procedure that would allow the CDDO to refuse to enter into or continue an affiliation agreement with any community service provider under any of these circumstances:

(1) If the provider refuses to accept a reimbursement rate for services to be provided that is at least equal to that established by the secretary to apply to the CDDO, or as agreed to in the affiliation agreement with the CDDO;

(2) if the provider has established a pattern of failing or refusing to abide by the service area procedures established by the CDDO according to K.A.R. 30-64-21, or failing to comply with its affiliation agreement with the CDDO; or

(3) if the CDDO demonstrates to the satisfaction of the secretary that being required to enter into the affiliating agreement would seriously jeopardize the CDDO's ability to fulfill its responsibilities either under these regulations or pursuant to its contract with the secretary. (Authorized by and implementing K.S.A. 39-1804, 39-1805, 39-1806, and 39-1810; effective July 1, 1996; amended Oct. 1, 1998; amended Feb. 1, 2002.)

**30-64-23. Single point of application,**



**determination, and referral.** (a) Each contracting CDDO shall develop and implement policies and procedures by which the CDDO shall act as the single point of application, eligibility determination, and referral for persons desiring to receive either information about community services or these services within the service area of that CDDO. Procedures shall be established for the following:

(1) Distributing, completing, accepting, and processing the uniform statewide application for community services, as published by the commission;

(2) determining if the applicant meets the definitional criteria to be considered a person with a developmental disability as defined in K.S.A. 39-1803, and amendments thereto;

(3) impartially informing a person of the types and availability of community services provided within the service area and of the licensed providers and other agencies existing within the service area that the CDDO has been advised might be willing to provide services to the person, and the way to contact those licensed providers or other agencies;

(4) impartially assisting a person in deciding which community services the person may wish to obtain or would accept within the next year from the date of the person's application;

(5) impartially assisting a person in accessing the community services of the person's choice;

(6) maintaining a list of persons who have made application to the CDDO for community services and have been determined eligible, and allowing access to this list, except for the names of those persons who have requested that their names be kept confidential by the licensed providers in the service area who have entered into affiliation agreements with the CDDO; and

(7) ensuring that when any person receiving any services expresses a desire to consider changing service providers, that person is referred directly and only to an individual who is not involved in the delivery of any service, has no involvement in any dispute about the person's current services, and honors the confidentiality of the person considering a change in service providers. The individual shall supply to the person and the person's guardian information about the types and availability of community services within the service area and assist the person in accessing alternative service providers.

(b) Each contracting CDDO shall require any

employees or agents of the CDDO who perform any of the functions specified in subsection (a) to maintain records that shall demonstrate compliance with these requirements.

(c) Each contracting CDDO shall require any employees or agents of the CDDO who perform the functions of determining eligibility, processing applications for service or referral of persons for service, or assisting persons in accessing services, to complete a training program that is approved by the division and meets these criteria:

(1) Is developed by the CDDO and approved by the CDDO council of community members required by K.A.R. 30-64-22(c);

(2) includes topics regarding the following:

(A) The types of community services available in the service area and information concerning the licensed providers and other agencies offering those services; and

(B) potential referral contacts for persons who are determined not to be eligible for services; and

(3) is offered in a manner and frequency that shall ensure that employees or agents of the CDDO who perform the duties required by subsection (a) are competent to do so. (Authorized by and implementing K.S.A. 39-1804, 39-1805 and 39-1810; effective July 1, 1996; amended Oct. 1, 1998; amended Feb. 1, 2002.)

**30-64-24.** (Authorized by K.S.A. 39-1810; implementing K.S.A. 39-1805 and 39-1806; effective July 1, 1996; amended Oct. 1, 1998; amended Aug. 23, 2002; amended Dec. 8, 2006; revoked May 30, 2008.)

**30-64-25. Uniform access to services.** (a) Each contracting CDDO shall implement a plan, developed in coordination with the CDDO's affiliates, that results in services being offered and provided in a way that does not discriminate against any person because of the severity of each person's disability.

(1) The plan may require all community service providers to serve all persons regardless of the severity of each person's disability.

(2) The plan may allow individual community service providers to specialize in services, if all persons are offered appropriate services without regard to the severity of each person's disability.

(b) The plan shall not require any community service provider to accept more persons than the community service provider can effectively serve. If all community service providers are at their maximum capacity, the CDDO shall, pursuant to

K.S.A. 39-1805(b), assist in establishing new community service providers.

(c) Notwithstanding these provisions, any CDDO that contracts with its affiliates and by mutual agreement provides its affiliates with financial consideration in excess of that required to be provided by the commission may require its affiliates to develop and make available appropriate services for any eligible person.

(d) Notwithstanding these provisions, a CDDO may refuse to serve a person who is determined by the secretary to be inappropriate for community services because the person presents a clear and present danger to self or to the community.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-64-26. Quality enhancement.** (a) Each contracting CDDO shall ensure that each service provided by the CDDO or by any affiliate shall be:

(1) provided as specified within, and in a manner that is responsive to, the person-centered support plan under which that service is being provided;

(2) provided in a manner that offers opportunities of choice to the person being served; and

(3) performed in a manner that ensures that all of the person's rights are observed and protected.

(b) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-64-27. Quality assurance.** (a) Each contracting CDDO shall ensure the quality of the services being provided to persons being served by the CDDO or by an affiliate. Ensuring quality shall include providing for on-site monitoring by a local committee made up of persons served, their families, guardians, interested citizens, and providers. The type and intensity of on-site review shall be determined by the local committee and shall include at least a determination of all of the following:

(1) Services that are paid for are delivered.

(2) Services that are delivered are paid for in accordance with the terms of any agreement or contract in force, including any payment requirement that the person being served or a third party acting on behalf of the person being served has the responsibility to meet.

(3) Services are being provided in a manner meeting applicable requirements provided for in article 63.

(4) The CDDO or affiliate is affording the person being served all of the person's legally protected rights.

(5) The CDDO or affiliate meets both of these requirements:

(A) Is reporting any suspicions of abuse, neglect, or exploitation to the appropriate state agency; and

(B) has corrected or is actively in the process of correcting the cause of any confirmed violation.

(b) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-64-28. Continuity and portability of services.** (a) Each contracting CDDO shall ensure both of the following:

(1) That each person who has applied for, accepted, and begun receiving community services continues to receive services consistent with the person's person-centered support plan, as long as state or federal funding support for those services continues, or until the person or the person's legal guardian, if one has been appointed, requests that services be discontinued; and

(2) that if the person moves from one service area to another and wants to continue receiving community services, the level of state and federal financial support utilized to provide services and supports for that person is transferred to the person's new service area.

(b) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

**30-64-29. Gatekeeping.** (a) Each request for admission to an ICF/MR or state institution shall be submitted to the CDDO responsible for the county in which the person is currently residing. The CDDO shall implement a procedure to review each request for admission to an ICF/MR or state institution. The procedure shall result in the following:

(1) Determining whether or not the person requesting admission has a developmental disability and is eligible for ICF/MR services using procedures and standards specified by the commission;

(2) determining if ICF/MR placement is con-

sistent with the person's preferred lifestyle as determined consistent with K.A.R. 30-63-21;

(3) informing the person, the person's family, and the person's guardian if one has been appointed, of all services or supports that are available or could be made available within 90 days in or near the person's home county, and of the person's rights pursuant to the developmental disabilities reform act and implementing regulations, the content of which shall be approved by the commission;

(4) offering to provide or arranging to provide these services or supports; and

(5) providing the commission with the results of items stipulated in (a)(1) through (a)(4) of this subsection for each person who requests admission to an ICF/MR or state institution, using forms specified by the commission, within 15 days of receiving information necessary to determine eligibility and preferred lifestyle.

(b) As described in this subsection, the CDDO shall implement a procedure to, at least annually, review the persons living in ICFs/MR and state institutions. The procedure shall result in all of the following:

(1) The CDDO whose service area includes the county in which the ICF/MR or state institution is located meets these requirements:

(A) Collecting information about the persons living in ICFs/MR and state institutions and submitting this data to the commission using standards, forms, and procedures specified by the commission; and

(B) making a determination regarding what the person's home county is and providing the CDDO whose service area includes the person's home county of the person's name and address, and the name and address of the person's family and guardian, if one has been appointed.

(2) The CDDO whose service area includes the person's home county informs the person, the person's family, and the person's guardian, if one has been appointed, of all services or supports that are available or could be made available in or near the person's home county, and of the person's rights pursuant to the developmental disabilities reform act and implementing regulations, the content of which shall be approved by the commission.

(3) The CDDO whose service area includes the person's home county provides or arranges to provide these services or supports if the person or

the person's guardian, if one has been appointed, chooses them.

(c) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-1801, et seq.; effective July 1, 1996; amended Oct. 1, 1998.)

### **30-64-30. Statewide service access list.**

Each contracting CDDO shall ensure that each person who has applied for services, been determined eligible for services, and agreed to accept services within the next year following the date of the person's application, but who cannot now be provided those services by either the CDDO, or any affiliate, because the maximum number of persons to be served as established in the contract with the secretary are already being served, or because supporting funding is not available, will receive the following services:

(a) Be assisted in the person's current setting by any means the CDDO can provide within existing resources in order to avoid as much as possible a crisis from developing until services can be arranged to be provided by the CDDO or an affiliate;

(b) be referred to other community agencies that may be able to provide any type of support or assistance appropriate to the needs of that person until services can be arranged to be provided by the CDDO or an affiliate;

(c) be reported to the secretary as waiting to access services in accordance with the division's policy governing service access lists; and

(d) be contacted at least annually from the initial application date to determine the continued need for services. (Authorized by and implementing K.S.A. 39-1804, 39-1805, and 39-1810; effective July 1, 1996; amended Feb. 1, 2002.)

**30-64-31. Council of community members.** (a) A council of community members organized according to K.A.R. 30-64-22(c) shall meet these criteria:

(1) Consist of a selected number of individuals, a majority of whom shall be made up of representatives from each of the following two categories:

(A) Persons with a developmental disability; and

(B) family members or guardians of a person with a developmental disability;

(2) include representatives from the following:

(A) The CDDO; and

(B) affiliates of the CDDO;

(3) not have served more than two consecutive three-year terms as members of the council;

(4) have the right to express opinions and make suggestions and recommendations to the governing board of the CDDO concerning any services issue, including the following:

(A) The types of services being offered by the various providers within the service area; and

(B) the manner in which those services are being provided;

(5) be responsible for the development and implementation of the dispute resolution procedures required by K.A.R. 30-64-32;

(6) be responsible for overseeing development, implementation, and progress reporting as to local capacity building plans, in accordance with guidelines provided by the division; and

(7) meet at least quarterly and at other times as necessary to fulfill the council's responsibilities for dispute resolution according to K.A.R. 30-64-32.

(b) For purposes of initial organization of the council, the CDDO shall appoint each member to the council. Thereafter, the selection of successor members of the council shall be determined pursuant to the bylaws or procedures agreed to and adopted by the council. Those bylaws or procedures shall stipulate a process by which consumer, family member, or guardian council members are chosen in an election by consumers, family members, and guardians following nominations by individuals residing in the service area.

(c) In order for a quorum to exist at any meeting of the council, at least 51 percent of those council members present and qualified to vote shall meet the provisions of both paragraphs (c) (1) and (2) below:

(1) Be any of the following:

(A) Persons being served;

(B) family members of persons being served;

or

(C) legal guardians of persons being served; and

(2) not also be either of the following:

(A) An employee or paid consultant to any provider or CDDO; or

(B) a member of the board of directors of any provider or CDDO. (Authorized by and implementing K.S.A. 39-1804, 39-1805 and 39-1810; effective July 1, 1996; amended Oct. 1, 1998; amended Feb. 1, 2002.)

**30-64-32. Dispute resolution.** (a) Each

contracting CDDO, in conjunction with the council of community members as specified in K.A.R. 30-64-31, shall develop and implement a dispute resolution procedure that shall provide persons being served by the CDDO, or by any community service provider affiliated with that CDDO, with a means for resolving disputes that may arise between the following:

(1)(A) The person;

(B) the person's legal guardian, if one has been appointed; or

(C) other individuals from the person's support network; and

(2)(A) The CDDO;

(B) an affiliated community service provider; or

(C) any other component of the community services system.

(b) These procedures shall provide a means for resolving disputes that may arise between any of the following:

(1) The CDDO and any affiliated community service provider;

(2) the CDDO and any entity that wishes to become an affiliated provider;

(3) the CDDO and any other component of the community services system;

(4) any affiliated community service providers; or

(5) any affiliated provider and any other component of the community service system.

(c) The procedures shall provide for the following:

(1) A local dispute-resolution process providing the opportunity for resolution between the disputing parties, to be completed no later than 20 calendar days following receipt of written notice to the CDDO of a dispute;

(2) an opportunity for the intervention into the dispute by a mediator who has no decision-making authority and is impartial to the issues being discussed, and a mechanism by which any fees charged by the mediator can be shared equally between the parties to the mediation. A person shall not be denied mediation services solely because of an inability to pay the applicable fee. Mediation shall be completed no later than 40 calendar days following the receipt of written notice to the CDDO of a dispute referred to in paragraph (c) (1) above. Any party to the dispute may decline to enter into any process of mediation if that party chooses to proceed directly to the appeal procedures provided for in paragraph (c) (3)



below. Any party to the dispute may withdraw from any mediation whenever that party believes further efforts at mediation will not likely result in resolution of the dispute; and

(3) the right of any party to the dispute to appeal to either of the following:

(A) The governing board of the CDDO, or any other body that the board may designate, if the dispute involves the CDDO as a party. The board shall have 20 days from the date of receipt of a written notice of appeal to conduct any appropriate proceedings and issue a written decision concerning the issues in dispute. If the board fails to issue a written decision by the end of this 20-day period, the appeal shall be deemed to have been decided in favor of the appellant. Each decision of the board shall be binding upon the parties unless either party further appeals to the commission as specified in paragraph (c) (3) (B); or

(B) the commission, unless the dispute involves the CDDO as a party, in which case the appeal shall first have been made to the governing board, as specified in paragraph (c) (3) (A). If the appeal is from a decision of the governing board of the CDDO, a written notice of appeal shall be delivered to the commission within 10 calendar days of the appealing party's receipt of the board's decision. If the dispute does not involve the CDDO as a party, a written notice of appeal shall be delivered to the commission within 60 calendar days following the CDDO's receipt of written notice of the dispute as specified in paragraph (c) (1) above. The authority to review the dispute and make an appropriate decision shall be reserved by the commission to assist the parties in resolving the dispute and preventing similar disputes in the future, including by requiring changes of policies, procedures, or practices of community service participants; by requiring corrective action or a peer review process by community service participants; or by using other resolution guidelines. The decision of the division may be appealed to the office of administrative appeals within the Kansas department of administration pursuant to article 7.

(d) Nothing in this resolution shall be construed to limit the right of any person to bring any action against a CDDO, any affiliated community service provider, or any other individual or entity as may be permitted by law. (Authorized by and implementing K.S.A. 39-1804, 39-1805 and 39-1810; effective July 1, 1996; amended Oct. 1, 1998; amended Feb. 1, 2002.)

**30-64-33. Fiscal management.** (a) Each contracting CDDO shall expend the funds received pursuant to its contract with the secretary only in accordance with the terms of that contract and this article.

(b) A contracting CDDO shall not use funds received through this contract to supplant funds previously received from local tax levies made pursuant to K.S.A. 19-4004, and amendments thereto.

(c) A contracting CDDO shall not transfer funds received through this contract from the CDDO to any other entity, except as authorized by that contract, or as otherwise expressly authorized in advance, in writing, by the department.

(d) All funds received by a contracting CDDO shall be subject to audit and review by the department.

(e) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 39-1801, et seq.; effective July 1, 1996.)

**30-64-34.** (Authorized by and implementing K.S.A. 39-1801, et seq.; effective July 1, 1996; revoked Feb. 1, 2002.)

#### **Article 65.—MENTAL RETARDATION DEVELOPMENTAL DISABILITY PROVIDER REVOLVING FUND**

**30-65-1. Eligible providers, loans, interest, repayment.** (a) Only providers of mental retardation or developmental disability (MR/DD) services otherwise recognized and approved pursuant to MR/DD programs administered by the department of SRS shall be eligible to participate in the MR/DD provider revolving fund program.

(b) Loans issued under this program shall not exceed the equivalent of the reimbursable sums which would be allowed for the particular services provided over a period of time not to exceed four months.

(c) Interest shall not be charged to the provider on any sums loaned.

(d) Each loan shall be repaid in accordance with the terms and conditions specified in that particular loan agreement, but in no case shall the term during which repayment is to be made exceed twice the length of time upon which the loan amount was calculated. If any provider becomes in arrears or in default on the provider's repayment, then those arrearages or unpaid sums may be offset and deducted by the department from any future reimbursement or grant awards due to

the provider from the department. (Authorized by and implementing L. 1993, Chapter 292, Sec. 30(b); effective, T-30-10-21-93, Oct. 21, 1993; effective Dec. 6, 1993.)

**30-65-2. Loan application, approval.** (a)

Any eligible provider may make application for a loan under this program by submitting the designated loan application form to the department. Each application shall:

- (1) Specify the individually named client who would be served with the proceeds of the loan;
- (2) specify the amount of the loan sought and the services upon which it is based;
- (3) include a proposed repayment schedule;
- (4) be signed by an authorized official of the provider; and
- (5) be accompanied by any additional information that may be required upon the application form, or that may be necessary to adequately explain the nature of the loan.

(b) Each loan application received by the department shall be reviewed and approved or denied within 14 days of receipt.

(1) Any application considered to be incomplete shall be denied, but may be resubmitted by the provider along with the additional information the department specifies as necessary to make the application complete.

(2) All loan approvals shall be subject to available resources.

(3) Nothing herein shall be construed to pre-

vent the department and provider from agreeing to some loan amount or term different from the amount or term sought in the loan application, so long as the final loan agreement is in compliance with the provisions of these regulations.

(c) A loan application shall not be approved for any provider whose cash reserves are more than the amount regularly necessary to cover two months' operating expenses, including any unusual debt due or expenses expected to be incurred within 90 days of the date of the loan application. (Authorized by and implementing L. 1993, Chapter 292, Sec. 30(b); effective, T-30-10-21-93, Oct. 21, 1993; effective Dec. 6, 1993.)

**30-65-3. Loan agreement, proceeds availability.** (a) Each loan approved by the department shall be evidenced by a loan agreement signed by the secretary and an authorized official of the provider. The agreement shall be on a form approved by the department for such purposes and shall specify:

- (1) The loan amount;
- (2) the repayment schedule; and
- (3) other terms and conditions which may be appropriate.

(b) The proceeds of each approved loan shall be made available only on or after the date the client receiving the services that are the subject of the loan is actually placed with the provider. (Authorized by and implementing L. 1993, Chapter 292, Sec. 30(b); effective, T-30-10-21-93, Oct. 21, 1993; effective Dec. 6, 1993.)